RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
E. KEVIN CLINTON, COMMISSIONER

STEVEN H. HILFINGER
DIRECTOR

January 12, 2012

MEMORANDUM

To: Health Care Providers, BCBSM Subscribers, Interest Groups, and Other Interested Parties

From: Susan M. Scarane SMS
Health Plans Division

Subject: Public Input on Blue Cross Blue Shield of Michigan's Hospital Provider Class Plan

Under 1980 P.A. 350, as amended, the Nonprofit Health Care Corporation Reform Act (Act), Blue Cross Blue Shield of Michigan (BCBSM) must develop and maintain a "provider class plan" for each type of health care provider that provides services to BCBSM subscribers. A provider class plan must include a description of the reimbursement arrangement used by BCBSM to pay providers; measurable objectives for meeting the access, quality of care, and cost goals specified by Section 504 of the Act; and, in the case of those providers with which BCBSM contracts, a copy of the provider contract. Each plan must also show how BCBSM proposes to balance the goals stated above.

Attached is a copy of Order No. 12-0001-BC, dated January 12, 2012, providing notice of intent to make a determination on the hospital provider class plan, pursuant to Section 509(2) of the Act. BCBSM's hospital provider class plan filed July 2, 2009 will be the subject of this review. These provider class plan documents are available on the OFIR website at www.michigan.gov/ofir.

Section 505(2) of the Act requires that the Commissioner of Financial and Insurance Regulation (OFIR) establish a procedure to gain input into the review and development of provider class plans prepared by BCBSM. Attachment A to the Order For Notice of Intent to Review contains a list of questions pertaining to the hospital provider class plan. We would appreciate any comments you may have with respect to these questions or any other matters concerning the hospital provider class plan.

Written testimony will be accepted through April 9, 2012, when mailed, faxed or e-mailed to:

Office of Financial and Insurance Regulation
Health Plans Division
Attention: Susan M. Scarane
P. O. Box 30220
Lansing, MI 48909
Fax: (517) 241-4168
E-mail: scaranes@michigan.gov

BCBSM is required to file an annual report for each provider class with the Commissioner of Financial and Insurance Regulation regarding the level of achievement of the above-mentioned goals. Pursuant to Section 517 of the Act, these reports need to include the data necessary to make a determination of BCBSM's compliance or noncompliance with the goals and compliance with objectives contained in each provider class plan. BCBSM's 2009-2010 annual report for the hospital provider class is available at the OFIR website at www.michigan.gov/ofir.

If you prepare and distribute a newsletter or other publication, I would ask that you include information about the opportunity to provide written testimony on BCBSM's hospital provider class plan in any such publication for the benefit of your readership. All of the BCBSM materials identified in this memorandum are available at the OFIR website at www.michigan.gov/ofir or you may obtain a copy of these documents by contacting Laurie VanBeelen at (517) 241-4549. Thank you for your assistance in this regard.

If you have any questions regarding the above referenced matter, please contact me at (517) 335-2052.

STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner

In the matter of notice of intent to make a determination with respect to the Hospital Provider Class Plan of Blue Cross Blue Shield of Michigan pursuant to Section 509(2) of 1980 P. A. 350

_____/

No. 12-001-BC

Issued and entered
this 12th day of January 2012
by R. Kevin Clinton
Commissioner

ORDER FOR NOTICE OF INTENT TO REVIEW

I

BACKGROUND

Section 509(1) of 1980 P. A. 350, as amended (Act), being MCLA 550.1101 et seq.; MSA 24.660 (101) et seq., allows the Commissioner of Insurance and Financial Regulation (Commissioner) to determine whether the arrangements Blue Cross Blue Shield of Michigan (BCBSM) has established with health care providers have substantially achieved the cost, access and quality of care goals set forth in the Act.

The Commissioner is required to evaluate enough BCBSM provider class plans to account for at least 75% of the corporation's provider payments during a 3-year period. The latest 3 year period began on January 1, 2010 and ends December 31, 2012. The Commissioner intends to review the provider class plan for hospitals at this time.

Section 509(2) of the Act requires the Commissioner to give written notice to BCBSM, and to each person who has requested a copy of such notice, of his intent to make a determination with respect to the provider class plan filed by BCBSM. Section 509(2) grants the Commissioner six months in which to reach his determinations.

Section 505(2) of the Act requires the Commissioner to establish and implement procedures whereby any person, including a subscriber, may offer advice and consultation on the development, modification, implementation, or review of provider class plans.

In addition to the requirement to gain input on the review and development of provider class plans, there is need to establish an accurate record of the comments presented to the Commissioner. The record can then serve as part of the basis for the determinations that will be made by the Commissioner with regard to BCBSM's achievement of the goals of Section 504.

II

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based upon the foregoing considerations, it is FOUND and CONCLUDED that:

1. Pursuant to Section 509(2) of the Act, the Commissioner shall give written notice to BCBSM, and to each person who has requested a copy of such notice, that he intends to make a determination with respect to a particular provider class plan. The Commissioner shall have 6 months in which to reach a determination.

2. Pursuant to Section 505(2) of the Act, the Commissioner must establish a procedure to gain input into the review and development of provider class plans prepared by BCBSM. The statute is silent as to the method chosen by the Commissioner to fulfill this responsibility.

3. The procedure established by the Commissioner should facilitate the presentation of information by any person and encourage input.

III

ORDER

Therefore, it is ORDERED that:

1. A determination shall be made with respect to the hospital provider class plan. The evaluation period shall include calendar years 2009 and 2010. A determination with respect to the hospital provider class plan will be made by July 12, 2012.

2. This order shall serve as notice of intent to make a determination with respect to the above stated provider class plan pursuant to Section 509(2) of the Act.

3. Questions of interest pertaining to the hospital provider class plan are included in Attachment A. Pursuant to Section 505(2), written comments will be accepted with regard to these questions or any other matters concerning the hospital provider class plan through April 9, 2012, when sent to:

Office of Financial and Insurance Regulation
Health Plans Division
Attention: Susan M. Scarane
P. O. Box 30220
Lansing, MI 48909
scaranes@michigan.gov

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further Order or Orders, as he shall deem just, necessary, and appropriate.

R. Kevin Clinton
Commissioner

BLUE CROSS BLUE SHIELD OF MICHIGAN
HOSPITAL PROVIDER CLASS PLAN
QUESTIONS OF INTEREST
JANUARY 12, 2012

ACHIEVEMENT OF STATUTORY GOALS

The Office of Financial and Insurance Regulation (OFIR) requires responses to the following questions to determine whether Blue Cross Blue Shield of Michigan's (BCBSM) provider contracts and reimbursement arrangements for hospitals have met the access, quality and cost goals specified in Section 504 of the Act:

1. Does BCBSM have participation agreements with an appropriate number of hospitals throughout Michigan to assure that each subscriber has access to covered services?

2. Has BCBSM established and maintained reasonable standards of health care quality for participating hospitals?

3. Do the reimbursement arrangements for hospitals assure that the rate of change in BCBSM payment per member to those providers is not higher than the compound rate of inflation and real economic growth?

The Commissioner has the authority to consider the overall balance of the goals achieved by BCBSM under the hospital provider class plan pursuant to Section 509 of the Act. The Commissioner is required to give weight to each of the goals set forth in Section 509(4) of the Act and shall not focus on one goal independently of the other goals. The Commissioner is also required to ensure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers. OFIR requests comments on how BCBSM's achievement of these goals can best be measured and evaluated.

ACHIEVEMENT OF BCBSM'S OBJECTIVES

BCBSM must include objectives in each provider class plan. These are expected achievement levels for the goals of reasonable access, cost and quality of health care services. The Commissioner is authorized to evaluate whether BCBSM has achieved these objectives for each provider class plan and how the objectives relate to the statutory goals. Comments regarding the appropriateness and importance of BCBSM's objectives will assist the Office of Financial and Insurance Regulation in making these determinations.

A. ACCESS:

The BCBSM access objectives in the hospital provider class plan under review are to:

- Provide direct reimbursement to participating providers who render medically necessary, high-quality services to BCBSM members.

- Communicate with participating providers about coverage determinations, billing, benefits, provider appeal processes, BCBSM's recordkeeping requirements and the participation agreement and its administration.
- Maintain and periodically update a printed or website directory of participating providers.

What types of information and data should the Office of Financial and Insurance Regulation examine to determine whether or not BCBSM has met its access objectives?

Would meeting BCBSM's access objectives be sufficient to assure that cost effective, quality services provided by hospitals are available, throughout the state, to BCBSM subscribers?

B. QUALITY OF CARE:

BCBSM's quality of care objectives for the hospital provider class plan under review are to:

- Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards.

- Maintain and update, as necessary, an appeals process that allows participating providers to appeal individual claims disputes and disputes regarding utilization review audits.

- Obtain continuous input from hospitals through the Contract Administration Process.

- Meet with provider organizations such as the Michigan Health and Hospital Association to discuss issues of interest and concern.

What types of information and data should the Office of Financial and Insurance Regulation examine to determine whether BCBSM has met its quality of care objectives?

Would meeting BCBSM's quality of care objective be sufficient to assure that hospitals actually meet and abide by reasonable standards of health care quality? Is it also necessary or desirable to consider:

1. Whether BCBSM has satisfactorily recognized changes that have taken place in the health care industry?

2. The ability of BCBSM to process claims in a reasonable and timely manner? Whether BCBSM has satisfactorily provided for a reasonable period for the implementation of policy and claims processing system changes?

3. The need for prompt, reasonable explanations from BCBSM regarding reimbursement issues, medical necessity determinations, audit determinations, etc.?

4. Whether BCBSM has established reasonable internal procedures for promptly resolving disputes?

C. COST:

BCBSM's achievement of this statutory goal is determined by the application of the cost goal formula found in Section 504 of the Act.

BCBSM's cost objectives in the hospital provider class plan under review are to:

- Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions

- Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participation agreement

As part of the review of the provider class plan, OFIR examines existing cost, utilization and communication patterns, the appropriateness of BCBSM's reimbursement arrangements with providers and the overall impact of access and quality of care concerns on cost goal achievement.

Retained provider class plans must comply with the standards set forth in Section 516 of the Act, including: responsible cost controls that balance quality, accessibility and cost, promotion of programs and policies which encourage cost-effective behavior by providers; a fair and reasonable appeals process for aggrieved providers; a reasonable period for implementation of changes; and reasonably prompt payment to providers. In addition, hospital provider class plans must also, in addition to the above standards, ensure that no portion of BCBSM's reasonable financial requirements are borne by other health care purchasers as well as ensure that BCBSM's programs and policies do not unreasonably interfere with a hospital's ability and responsibility to manage its operations.

OFIR welcomes comments on the appropriateness of BCBSM's reimbursement arrangements with hospitals, focusing on whether or not: such reimbursement arrangements assure: 1) a rate of change in BCBSM payment per member that is not higher than the compound rate of inflation and real economic growth; and, 2) that no portion of BCBSM's reasonable financial requirements are borne by other health care purchasers.

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Hospital Provider Class Plan Detailed Report 2009-2010

EXECUTIVE SUMMARY

Goal Achievement

BCBSM met the cost, access and quality of care goals during the reporting period.

Cost Performance

During the 2009-2010 reporting period, the two-year average percent change in hospital payments per 1000 members decreased 0.3 percent. The PA 350 cost goal was to limit the increase to 0.5 percent. The downward trend was due to an average decrease in use of almost 8 percent for inpatient admissions and a 7.2 percent decrease in the average payment per visit for outpatient services. Additional factors are summarized below:

- Traditional membership continues to decline as does utilization of benefits. The average number of inpatient admissions decreased 7.8 percent, however; the average cost per admission increased 10.3 percent, indicating a more intensive mix of services. The average payment for outpatient services also decreased 2.2 percent due to a 7.2 percent decrease in the average payment per service, indicating a lower intensity of services in the outpatient location.
- The majority of hospital payments were for members in the age category 55 years and older, a population for which the demand for hospital care and health resources will continue to rise as they continue to age.
- Circulatory, musculoskeletal, digestive and respiratory conditions experienced a three-year payout that accounted for 53 percent of total inpatient payments. Diagnoses codes associated with these conditions included angina, heart attacks, irregular heart rhythms, osteoarthritis, spinal stenosis, diverticulitis, appendicitis, acute respiratory failure and pneumonia.
- Surgery, laboratory/pathology and diagnostic X-ray accounted for 67 percent of the total three-year outpatient payout. In many respects, these top three types of service are used in conjunction with one another to provide patient care. Review of the major diagnostic categories showed that the Traditional hospital membership tends to be older with cardiac and musculoskeletal issues that would require the use of surgery, laboratory/pathology and diagnostic X-ray types of service.

Access Performance

There was a 100 percent formal hospital participation rate throughout the state to ensure the availability of inpatient and outpatient services to each BCBSM member. Major factors affecting access and performance during this reporting period included:

- Effective communications with hospitals, such as BCBSM publications, on-line assistant tools, and provider consultants helped maintain a strong working relationship with hospitals.
- BCBSM's reimbursement methodology, which is outlined in the provider participation agreement, provided hospitals with equitable income to provide services to our members.

- Financial incentives offered to hospitals for focusing on quality improvement measures, hospital efficiency and collaborative quality initiatives helped to impact the safety and quality of services provided to the Michigan community.
- Hospital satisfaction surveys measured hospital leaders' and staffs' satisfaction with BCBSM's services, operations and hospitals' overall relationships with BCBSM. The survey results helped BCBSM assess what was done well and where opportunities for improvement exist.

Quality of Care Performance

BCBSM ensured that hospitals met and abided by reasonable standards of health care quality. Major factors affecting quality of care performance during this reporting period included:

- Qualification standards required for participation ensured that providers were appropriately licensed and accredited.
- Quality controls implemented through a variety of audits helped ensure that services rendered were medically necessary and provided in the appropriate setting.
- Quality management initiatives, including the Participating Hospital Agreement Pay for Performance Program and several other programs promoted safety and ensured the delivery of high quality health care.
- Effective provider relations, including the contract administration process and the provider appeals process, helped ensure quality care was available to BCBSM members.

PLAN OVERVIEW

Providers

Short-term general acute care hospitals, short-term acute psychiatric hospitals and intensive rehabilitation hospitals.

Qualifications

Licensed by the state of Michigan; certified by the Centers for Medicare and Medicaid Services (CMS); accredited by The Joint Commission or American Osteopathic Association (AOA) or the Commission on Accreditation of Rehabilitation Facilities.

Participation Status

Formal basis only

Covered Services

BCBSM reimburses only for covered services provided by a participating hospital in accordance with member certificates*. Services provided at a hospital include but are not limited to:

- Room and board
- Surgery
- Maternity care and delivery
- Newborn care
- Emergency treatment
- Dialysis
- Physical therapy
- Chemotherapy
- Pathology and laboratory
- Radiology – diagnostic
- Observation bed
- Medical supplies

* Emergency services may also be covered by an accredited nonparticipating hospital.

Benefit Issues

There were no benefit issues in this reporting period.

Plan Updates

No plan changes in 2010.

EXTERNAL INFLUENCES

Market Share

Table 1 illustrates BCBSM's commercial (private) market share for members with Traditional hospitalization benefits. As shown, BCBSM's share of the commercial market in Michigan decreased in every region between 2009 and 2010. Total market share in Michigan decreased from 2.2 percent in 2009 to 1.9 percent in 2010.

Table 1
Traditional Hospital Share of Michigan Market

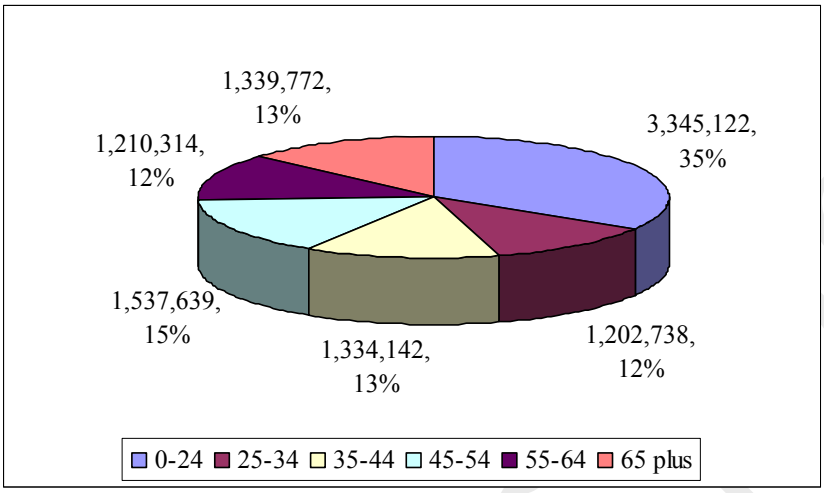
Region	2010 Michigan Population*	2010 BCBSM Hospital Members	2010 Market Share	2009 Michigan Population*	2009 BCBSM Hospital Members	2009 Market Share
1	2,800,026	49,673	1.8%	2,958,016	64,576	2.2%
2	372,211	7,425	2.0%	393,213	9,159	2.3%
3	411,792	7,957	1.9%	435,027	10,165	2.3%
4	315,149	4,940	1.6%	332,932	5,552	1.7%
5	697,961	13,672	2.0%	737,343	18,664	2.5%
6	822,728	18,266	2.2%	869,150	19,975	2.3%
7	456,480	8,632	1.9%	482,237	10,011	2.1%
8	304,306	5,199	1.7%	321,476	6,374	2.0%
9	211,206	2,751	1.3%	223,123	3,156	1.4%
Statewide	**6,391,859**	**118,515**	**1.9%**	**6,752,518**	**147,633**	**2.2%**

* Excludes Medicare and Medicaid recipients

Demographics

The characteristics of a population may significantly affect that population's consumption of health care resources. Michigan residents aged 45-64 comprised 27 percent of the state's overall population compared to 22 percent for the same age group in the United States. Michigan's median age of 37.7 is slightly higher than the national median age of 36.7. Chart 1 (see next page) provides a distribution of Michigan's population in 2009 by age group.

Chart 1
2009 Michigan Population by Age Category



Epidemiological Factors

The type of care rendered in the hospital setting is directly related to the health status of the population. Health status is affected by a number of different factors including demographics, the environment, prevalence of chronic disease and accidents/injuries as well as lifestyle choices.

While today's rates of chronic conditions are high, the proportion of the population affected by one or more chronic diseases is expected to grow. Currently, 78 percent of U.S. health care spending is for people with chronic conditions and almost one half of Americans live with at least one chronic disease or disability.[1]

Based on data for 2009, Michigan outranks most states in the percent of the adult population with chronic conditions such as:

- Obesity – Michigan ranked 10th in the nation, with an obesity rate of nearly 30 percent. Obesity is a major risk factor for a number of chronic conditions including diabetes, hypertension, cardiovascular disease and cancer.[2]
- Diabetes – Michigan had an adult diabetes rate of 9.4 percent compared to the national rate of 8.4 percent.[3]
- Hypertension – Michigan ranked 16th in the nation, with 28.7 percent of the population diagnosed with hypertension.[4]
- Cancer- Michigan ranked 8th in the nation in the estimated number of new cases of cancer.[4]

[1] http://michigan.gov/documents/Healthy_Michigan_2010_1_88117_7.pdf
[2] http://www.michigan.gov/documents/mdch/CHI2010_WebFinal-13_340401_7.pdf
[3] http://www.michigan.gov/documents/mdch/CHI2010_WebFinal-06_340393_7.pdf
[4] http://healthyamericans.org/states/?stateid=MI

Michigan also fares poorly with respect to the prevalence of lifestyle factors that contribute to chronic health conditions, such as smoking, lack of exercise and diet.[4] Chronic diseases, such as heart disease, stroke, cancer and diabetes are among the most prevalent, costly and preventable of all health problems.

Economic Factors

National Health Expenditures and Projections

In 2010, total national health expenditures were projected to rise 5.1 percent reaching $2.6 trillion dollars. Total health care spending represented 17.5 percent of gross domestic product in 2010. The anticipated acceleration in growth over the coming decade is expected to be the result of the implementation of the Patient Protection and Affordable Care Act as well as increases in subsidized coverage provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA).[5]

The hospital care component of national health expenditures rose 5.1 percent in 2009 and is projected to rise an average of 6.1 percent through 2019.[6]

Inflationary Factors

As mentioned in the epidemiology section, the impact of chronic disease on health care costs cannot be ignored. Diagnoses related to obesity, diabetes and cardiovascular disease have consistently affected health care costs. The growth in chronic conditions and an aging population are increasing utilization of health services. At the same time, technological advances continue to provide new treatment options, which drive up the cost of care. For example, advanced techniques and technologies have revolutionized hip replacements, allowing more arthritis patients to consider treatments at an earlier stage than they had in the past.[7]

Health Care Cost Containment

Many approaches are used to control health care spending, including provider pay-for-performance programs and promotion of healthy lifestyles. Programs like these have the potential to mitigate future cost increases and address some of the root cost drivers.

Hospitals themselves strive to contain costs by minimizing length of stay by utilizing other appropriate settings such as skilled nursing facilities or home health care when acute care is no longer necessary.

Regulatory Programs

Several state and federal programs in effect during the reporting period impacted cost, quality and access to care. Michigan's Department of Licensing and Regulatory Affairs administers

[4] http://healthyamericans.org/states/?stateid=MI
[5] http://www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf
[6] https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp#TopOfPage
[7] http://www.hipreplacement.com/DePuy/treatment/index.html

minimum standards for hospitals which must be met to obtain a state license as a hospital. BCBSM requires participating hospitals to have and maintain current state licensure to ensure quality facilities are available to its members.

Michigan's Certificate of Need (CON) Program strives to achieve a balance between cost, quality of and access to health care. The Certificate of Need Commission is an 11 member independent body appointed by the governor that develops, approves, disapproves, or revises CON Review Standards for determining need and ongoing quality assurance standards for health facilities and covered clinical services. BCBSM requires participating hospitals to comply with the CON requirements of the Michigan Public Health Code.

The Centers for Medicare and Medicaid Services has Conditions of Participation (CoP) and Conditions for Coverage (CfC) that health care organizations must meet to begin and continue to participate in the Medicare and Medicaid programs. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CoPs apply to many facilities, including hospitals.[8] In turn, one of BCBSM's qualification standards under the Hospitals Provider Class Plan is Medicare certification as a hospital.

The Michigan Health Information Network (MiHIN) is the state of Michigan's initiative to improve health care quality, cost, efficiency, and patient safety through electronic exchange of health information. It is focused on designing a system to create electronic medical records that can be securely and confidentially delivered amongst various providers that are involved in a patient's care. MiHIN is also an essential part of ensuring that Michigan's health care providers can utilize electronic health records (EHR) in a way that meets the federal criteria for Medicare and Medicaid EHR incentive programs.[9]

[8] http://www.cms.gov/CFCsAndCoPs/01_Overview.asp#TopOfPage
[9] http://www.michigan.gov/mdch/0,1607,7-132--248053--,00.html

COST GOAL PERFORMANCE

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." This is expressed by the following formula:

$$\left[\frac{(100 + I) * (100 + REG)}{100}\right] - 100$$

PA 350 Cost Objectives

Objectives

- Strive toward meeting the cost goal within the confines of Michigan and national health care market conditions
- Provide equitable reimbursement to participating providers through the reimbursement methodology outlined in the participating agreement

Performance - Cost Goal and Objectives

BCBSM's two-year average percent change in payments per 1000 members decreased 0.3 percent for the hospital provider class (shown in Table 2). BCBSM did meet the PA 350 cost goal of 0.5 percent.

In 2010, decreased utilization (admissions per 1000 members) in the inpatient location and decreased average payment per service in the outpatient settings were the primary factors affecting the total hospital payments per 1000 members. As with the previous reports, Traditional membership continues to decline; however, utilization of benefits by existing members grew considerably due to the aging of this population. This resulted in higher payments per inpatient admission as well as increased visits at the outpatient location.

Table 2
Hospital Provider Class
2009-2010 Performance against Cost Goal

	2010	2009	2008
Payments			
Inpatient and Outpatient	$324,247,675	$410,852,747	$430,509,286
Per 1,000 members	$2,735,924	$2,782,940	$2,753,941
% change	-1.7%	1.1%	
Members	118,515	147,633	156,325

Achievement of Cost Goal			
Two Year Average Percent Change:	**-0.3%**	***2010 percent of Total Payout reported to OFIR****	**8.1%**
PA 350 Cost Goal	**0.5%**		
Goal Met		***2010 ASC Business***	**61.4%**

*Payout reported to OFIR includes Traditional claims for the hospital, MD, DO, clinical laboratory, fully licensed psychologist, CLMSWs, ESRD, podiatrist, rehabilitation therapy and chiropractor provider classes. Traditional and PPO claims are included for the outpatient psychiatric care, substance abuse, SNF, LTACH, home health care, ASF, hospice, DME/P&O, ambulance, nurse specialists, HIT, UCC, dental, vision, hearing and pharmacy provider classes. See the technical notes section for more details.

Total payment of the hospital provider class accounted for 8.1 percent of total BCBSM payments during this reporting period, a decrease from 2009 of 6.5 percentage points. Overall, hospital cost performance showed the trend in hospital payments per 1000 members remaining relatively flat, while membership continued to decline. The hospital payment per 1000 members decreased approximately $47,016 or 0.3 percent from 2009 to 2010, while membership decreased approximately 30,000 members or 19.7 percent.

The cost section of this report provides a detailed analysis of factors impacting the increases in hospital costs for both the inpatient and outpatient settings. The tables provided in this discussion represent the most significant health care benefit categories such as major diagnostic categories, diagnosis related groupings and top diagnoses. Additional supporting data for each individual year is found in Appendix C.

Table 2A
Inpatient Hospital Provider Class
2009-2010 Cost, Use and Price Trends

	2010	2009	2008
Payments			
Total	$176,189,256	$233,925,115	$225,782,685
Per 1,000 members	$1,486,643	$1,584,508	$1,444,318
% change	-6.2%	9.7%	
Admissions			
Total	12,916	18,423	20,121
Per 1,000 members	108.98	124.79	128.71
% change	-12.7%	-3.0%	
Payment/ Admissions	$13,641.16	$12,697.45	$11,221.25
% change	7.4%	13.2%	
Members	118,515	147,633	156,325

Table 2B
Outpatient Hospital Provider Class
2009 – 2010 Cost, Use and Price Trends

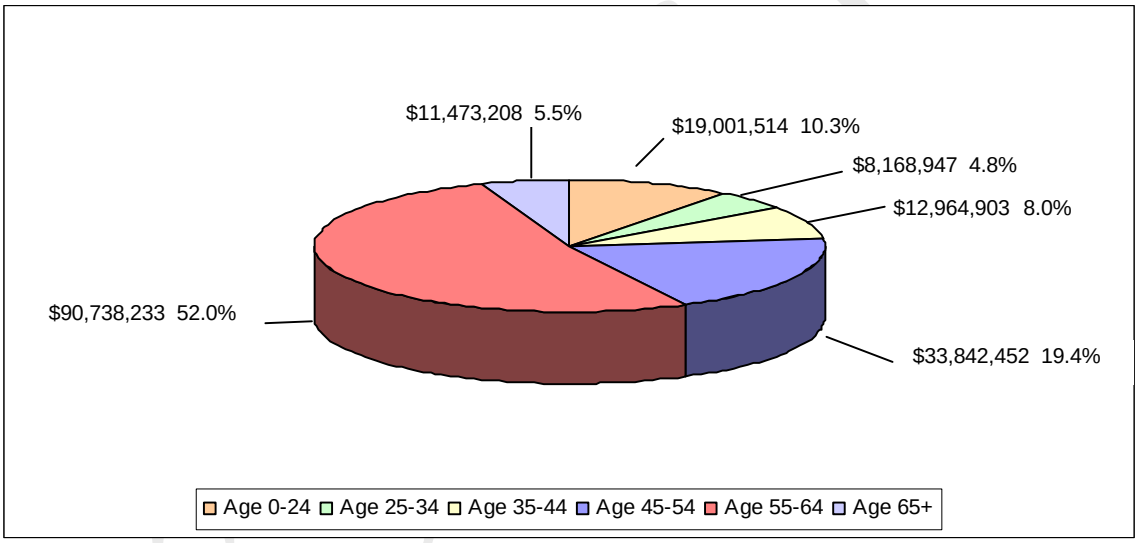
	2010	2009	2008
Payments			
Total	$148,058,419	$176,927,632	$204,726,602
Per 1,000 members	$1,249,281	$1,198,432	$1,309,623
% change	4.2%	-8.5%	
Visit			
Total	3,573,764	4,340,073	4,212,154
Per 1,000 members	30,154.56	29,397.79	26,944.89
% change	2.6%	9.1%	
Payment/Visit	$41.43	$40.77	$48.60
% change	1.6%	-16.1%	
Members	118,515	147,633	156,325

Inpatient Cost, Use and Price

Hospital inpatient costs decreased $97,865 per 1000 members, or an average of 6.2 percent during this reporting period. The cost decrease was the result of a significant decrease in admissions that averaged 7.8 percent. As membership and utilization have declined during the reporting period, the percentage of patients using benefits has also declined from 10.1 percent in 2008 to 8.8 percent in 2010.

As shown in Chart 2, the age group responsible for 52 percent of inpatient payout during 2010 was members aged 55 years and older.

Chart 2
Hospital Provider Class
2010 Inpatient Payments by Age



In 2006, almost 500 million people worldwide were 65 years or older. By 2030, that total is projected to increase to 1 billion-1 in every 8 of the earth's inhabitants.[10]

Increased life expectancies have already impacted the number of chronic conditions, injuries and disabilities that require medical treatment. The next section examines the distribution of inpatient payments among each of the major diagnostic categories and their impact on overall costs.

[10] http://www.nia.nih.gov/NR/rdonlyres/9E91407E-CFE8-4903-9875-D5AA75BD1D50/0/WPAM.pdf

Major Diagnostic Category

Table 3
Hospital Provider Class
2008-2010 Inpatient Payments by Major Diagnostic Category

Inpatient Hospital by Major Diagnostic Catergory	Two year average rate of change Per 1000 Members				2008-2010 Payments	2008-2010 Adm	2008-2010 Avg Pmt/Adm	Pct to Total Payout
	Payments	Days	Adm	Pmt/Adm				
Nervous System	1.1%	-1.6%	-7.6%	8.3%	$ 38,826,747	2,202	$ 17,632	6.1%
Disease of the Eye	1.7%	-1.5%	7.3%	-0.1%	$ 358,404	54	$ 6,637	0.1%
Disease of ENT	6.2%	-9.9%	1.4%	5.4%	$ 4,703,965	516	$ 9,116	0.7%
Respiratory System	-1.6%	-12.9%	-8.7%	7.9%	$ 51,534,740	4,063	$ 12,684	8.1%
Circulatory System	-2.5%	-11.4%	-9.2%	7.4%	$ 103,402,219	5,026	$ 20,573	16.3%
Digestive System	9.0%	-2.6%	-0.6%	9.4%	$ 58,720,479	4,815	$ 12,195	9.2%
Hepatobiliary Sys/Pancreas	-0.3%	-10.6%	-7.2%	5.0%	$ 24,237,509	1,594	$ 15,205	3.8%
Musculoskeletal	11.7%	-2.9%	-1.7%	13.6%	$ 124,440,600	6,712	$ 18,540	19.6%
Skin & Subcutaneous Disease	16.5%	7.3%	4.8%	13.0%	$ 9,918,866	1,232	$ 8,051	1.6%
Nutritional Disease	-2.1%	-11.2%	-6.3%	4.5%	$ 24,606,017	2,075	$ 11,858	3.9%
Kidney/Urinary Tract	7.1%	-7.3%	-1.9%	9.1%	$ 17,361,620	1,577	$ 11,009	2.7%
Male Reproductive Sys	13.5%	2.5%	-0.4%	14.4%	$ 4,940,908	461	$ 10,718	0.8%
Female Reproductive Sys	-0.3%	-14.0%	-12.8%	13.9%	$ 19,074,350	2,121	$ 8,993	3.0%
Pregnancy	-9.5%	-14.3%	-13.6%	5.0%	$ 24,659,070	5,585	$ 4,415	3.9%
Newborns in Perinatal Period	-8.2%	-42.0%	-13.2%	5.6%	$ 17,933,340	5,123	$ 3,501	2.8%
Disease of the Blood	0.3%	-18.9%	-7.9%	9.0%	$ 6,926,506	617	$ 11,226	1.1%
Neoplasms	-7.0%	-15.8%	-7.1%	2.9%	$ 17,017,009	489	$ 34,800	2.7%
Infectious Disease	5.7%	-3.1%	2.8%	2.2%	$ 26,623,449	1,138	$ 23,395	4.2%
Mental Disorders	-17.9%	-20.8%	-21.9%	5.8%	$ 15,151,643	2,497	$ 6,068	2.4%
Alcohol/Drug Abuse	-13.2%	-14.7%	-12.0%	-1.4%	$ 1,271,367	183	$ 6,947	0.2%
Injury Poisoning	-0.9%	-13.9%	-6.6%	7.2%	$ 16,294,711	1,307	$ 12,467	2.6%
Burns	-18.6%	-39.3%	-18.1%	-3.3%	$ 563,625	26	$ 21,678	0.1%
Factors Influencing Health Status	2.3%	-11.7%	-8.1%	11.2%	$ 24,675,353	1,835	$ 13,447	3.9%
Human Immunodeficiency Virus Infections	57.0%	67.7%	8.1%	4.4%	$ 1,048,718	16	$ 65,545	0.2%
Other	1543.2%	1484.6%	17.6%	1117.8%	$ 1,605,841	196	$ 8,193	0.3%
Total	**1.8%**	**-11.2%**	**-7.9%**	**10.3%**	**$ 635,897,056**	**51,460**	**$ 12,357**	**100%**

Major diagnostic categories (MDC) identify the main reason for an inpatient encounter. MDC's are a clinically coherent grouping of diagnoses by major organ system or etiology and allow for a broad definition of a patient's experience.

As shown in Table 3, the circulatory, musculoskeletal, digestive and respiratory MDCs three-year payout accounted for 53 percent or almost $338 million of total inpatient payments.

- Musculoskeletal conditions had the highest payout at 19.6 percent of total inpatient payments. The total payment for this major diagnostic category increased 11.7 percent, caused by an almost 2 percent decrease in admissions per 1000 members essentially offset by a 13.6 percent increase in the average price per admission, indicating more costly or intense services were required. It is estimated that the annual direct and indirect costs for bone and joint health will be $849 billion or 7.7% of the gross domestic product. Approximately one in every four Americans has a musculoskeletal impairment that limits or decreases their ability to function at home, work or play. This percentage is expected to grow as the population increases in age.[11]

[11] http://www.boneandjointburden.org/

- Even though circulatory conditions had the second highest payout at 16.3 percent of total inpatient payments, the average payment per 1000 members decrease of 2.5 percent. This decrease was due to a 9.7 percent decrease in the average number of admissions partially offset by a 7.4 percent increase in the average price per admission. Disorders of the circulatory system generally result in diminished flow of blood and diminished oxygen exchange to the tissues potentially resulting in conditions such as heart attack and stroke.[12] In 2010, the total costs of cardiovascular diseases in the United States were estimated to be $444 billion. Treatment of these diseases accounts for about $1 of every $6 spent on health care in this country. As the U.S. population ages, the economic impact of cardiovascular diseases on our nation's health care system will become even greater.[12]

- Payments per 1000 for digestive conditions increased 9.0 percent during 2010, mainly due to a 9.4 percent increase in the average price per admission. Conditions for this population included diagnoses such as bowel procedures, gastrointestinal disorders, hernias and appendectomies. Over 95 million Americans experience some kind of digestive problem. Over 13 million people are hospitalized each year for care of gastrointestinal problems and the total health care costs exceed $141.8 billion annually. While many digestive problems are more common as people get older, they can occur at any age, even in children. All Americans are susceptible to digestive problems, regardless of gender, ethnic or socioeconomic backgrounds.[13]

- Respiratory conditions payments per 1000 members decreased by 1.6 percent. This was due to an 8.7 percent decrease in the admission rate partially offset by a 7.9 percent increase in the average cost per admission. Conditions afflicting members during 2010 included respiratory failure, pneumonia, pulmonary embolisms, COPD and asthma. The number of people with asthma continues to grow: it is estimated that one in 12 people (about 25 million, or 8% of the population) have asthma.[14] Approximately, 12 million adults have been diagnosed with COPD and it is estimated that an approximately equal number have not been diagnosed.[15] Because of the cost to the health care system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual health care expenditures for asthma alone are estimated at $56 billion.[16]

[12]http://www.infoplease.com/ce6/sci/A0857356.html
[13] http://www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm
[14]http://www.cdc.gov/vitalsigns/asthma/
[15]http://www.nhlbi.nih.gov/health/public/lung/copd/
[16]http://www.aaaai.org/about-the-aaaai/newsroom/asthma-statistics.aspx

Diagnostic Related Groups

Table 4
Hospital Provider Class
2008-2010 Inpatient Payments by Top 10 Diagnostic Related Groups

Diagnositc Related Group	Two year average rate of change Per 1000 Members				2008-2010 Payments	2008-2010 Days	2008-2010 Adm	2008-2010 Avg Pmt/Case	Pct to Total Payout
	Payments	Days	Admissions	Pmt/Adm					
Spinal Fusion Except Cervical W/O Mcc	25.8%	5.8%	10.7%	14.0%	$ 14,619,403	1,880	524	$ 27,900	2.30%
Signs & Symptoms Of Musculoskeletal System & Conn Tissue	6.1%	-2.8%	-1.6%	9.2%	$ 11,410,699	1,206	581	$ 19,640	1.79%
Ecmo Or Tracheostomy With Mechanical Ventilation 96+ Hours	-7.4%	-9.9%	-11.8%	5.8%	$ 12,238,998	2,349	67	$182,672	1.92%
Septicemia Or Severe Sepsis Without Mechanical Ventilation 96+ Hrs With M	32.2%	14.2%	21.0%	10.3%	$ 5,397,862	1,831	255	$ 21,168	0.85%
Uterine And Adnexa Procedure For Non-Malignancy Without Cc/Mcc	16.7%	13.3%	6.5%	9.6%	$ 5,804,366	2,998	964	$ 6,021	0.91%
Rehabilitation W Cc/Mcc	-1.2%	-12.0%	-7.8%	8.4%	$ 5,862,129	1,229	465	$ 12,607	0.92%
Vaginal Delivery W/O Complicating Diagnoses	14.7%	11.3%	11.4%	6.8%	$ 4,472,820	925	109	$ 41,035	0.70%
Urethral Stricture Age 0-17	9.0%	6.0%	-2.6%	12.9%	$ 4,484,322	534	318	$ 14,102	0.71%
O.R. Procedures For Obesity Without Cc/Mcc	-6.2%	-18.0%	-13.5%	11.7%	$ 5,265,627	2,085	146	$ 36,066	0.83%
Splenectomy Age >17	19.5%	14.8%	8.3%	9.4%	$ 6,178,707	3,215	1,033	$ 5,981	0.97%
Top 10	**10.5%**	**1.8%**	**2.7%**	**1.1%**	**$ 72,164,779**	**15,567**	**3,476**	**$ 20,761**	**11.35%**
Top 50	11.1%	-1.4%	-0.5%	11.3%	$ 278,887,228	80,968	21,974	$ 12,692	43.86%
Grand Total	**1.8%**	**-11.3%**	**-7.9%**	**10.3%**	**$ 635,897,056**	**205,249**	**51,460**	**$ 12,357**	**100.00%**

It is helpful in the process of reviewing MDC's cost and use experience to also examine diagnosis codes. Table 4 shows the top 10 diagnostic related groups by payout. Diagnostic related groupings (DRG) are a system for classifying inpatient care; the purpose is to provide a framework for specifying case mix. BCBSM's top 10 diagnostic related groups accounted for approximately $72 million or 11.4 percent of total inpatient payout, and had an average increase in payments per 1000 members of 10.6 percent. Arthritis, back issues, ECMO and mechanical ventilation were among the top DRGs by payout. These DRGs as well as many in the Top 50 (shown in Appendix C) reflect the circulatory, musculoskeletal, digestive and respiratory MDCs described in the previous section as drivers in the increased hospital inpatient trend.

Spinal Fusions accounted for the highest inpatient cost with 2.3 percent of the total payments. The total average payment for this DRG increased 25.8 percent due to a 10.7 percent increase in admissions and a 14.0 percent increase in the average cost per admission. With an aging population lumbar surgery is on the rise and according to Dartmouth researchers and the rate of lumbar fusions in the United States have increased more that 250 percent over the past decade. In addition, the cost increase in spinal fusions has been more than 500 percent among Medicare patients.[17] Spinal fusion are a very reliable way to reduce pain in the spine and can be successful in improving quality of life, and as people become more aware of the successes of these procedures and improvement in techniques, studies suggest that the demand for these surgeries may overwhelm supply. In addition, as the number of spinal surgeries increase, so will the need for rehabilitation services.

[17]http://www.dartmouth.edu/~news/releases/2006/10/17.html

The second highest inpatient cost was for ECMO (extracorporeal membrane oxygenation). ECMO is a technique providing both cardiac and oxygen respiratory support to patients whose heart and lungs are so severely damaged that they can no longer serve their function. ECMO is most commonly used in NICUs (neonatal intensive care units), for newborns in pulmonary distress.[18] During this reporting period, the DRG for ECMO experienced a decrease in payments per 1000 members of nearly 7.4 percent; almost entirely due to an 11.8 percent decrease in the average number of admissions.

Signs and symptoms of musculoskeletal system and connective tissue accounted for the third highest inpatient cost with 1.8 percent of the total payments. The average payment per admission for this service was $19,640. One of the main diagnoses associated with this DRG is arthritis-both osteo and rheumatoid arthritis. With an aging population joint replacement surgery is on the rise, and according to findings presented at the annual meeting of the American Academy of Orthopedic Surgery, it is expected that the number of total knee replacements performed in the U.S. will leap by 673% -- reaching 3.48 million -- by the year 2030 and hip will increase by 174 percent by 2030.[19] Joint replacement is very successful in improving quality of life, and as people become more aware of the successes of these procedures and improvement in techniques, studies suggest that the demand for these surgeries may overwhelm supply. In addition, as the number of hip and knee replacement surgeries increase, so will the need for rehabilitation services.

In intensive care medicine, mechanical ventilation is a life support therapy used to sustain breathing as well as provide oxygen and carbon dioxide removal to patients whose lungs are damaged so that that they can no longer serve their function effectively. Mechanical ventilation patients are put on a mechanical ventilator when they are in respiratory failure. Respiratory failure is the situation when the patient has a low level of oxygen in the blood, even while getting oxygen therapy and/or when the level of carbon dioxide rises too much in the blood.[20] During this reporting period, the DRG for mechanical ventilation experienced an increase in payments per 1000 members of nearly 32.2 percent; due to a 21.0 percent increase in the average number of admissions and a of 10.3 percent increase in the average price per admission.

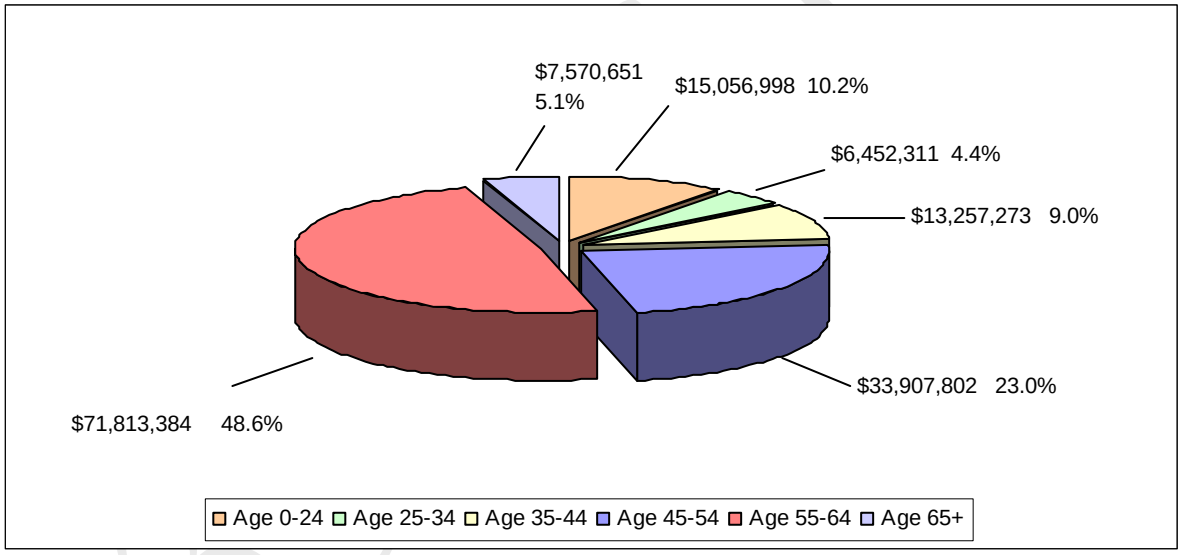
[18]http:// http://emedicine.medscape.com/article/1818617-overview
[19]http:// http://www.webmd.com/osteoarthritis/news/20060324/joint-replacement-surgery-on-rise
[20]http://www.thoracic.org/clinical/critical-care/patient-information/icu-devices-and-procedures/mechanical-ventilator.php

Outpatient Cost, Use and Price

Total three-year payout for outpatient hospital care was almost $530 million during this reporting period. The two-year average outpatient decrease in payments per 1000 members was 2.1 percent, as a result of a 5.8 percent rise in utilization partially offset by a 7.2 percent decrease in the average payment per service.

Similar to inpatient, members aged 55 years and older accounted for almost 50 percent of total payout (Appendix C), and the percentage of patients using outpatient benefits increased from approximately 93 to 96 percent in 2009 and 2010, respectively. Indicating that even though membership is declining the number of patients using the benefit is increasing.

Chart 3
Hospital Provide Class
Outpatient Payments by Age



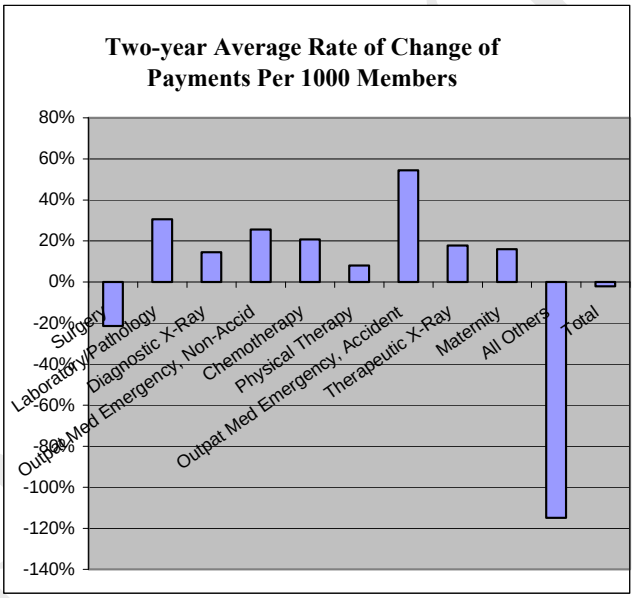
Between now and 2019, the health care industry will see demand for outpatient services increase by nearly 22% while demand for inpatient services is projected to remain flat, according to Sg2, a future-focused health care information systems company.[21] As a result, with the aging baby boomer population, demand for outpatient services will continue to grow at even faster rates as advances in medical technology and patient treatments have resulted in more minimally invasive procedures and treatment and management of some diseases on an ambulatory basis.[22]

[21]http://www.news-medical.net/news/20100106/Sg2-Demand-for-outpatient-services-to-increase-by-nearly-2225-over-the-next-decade.aspx
[22]http://www.hss-inc.com/pdfs/1-06-1hss.pdf

Type of Service

Table 5
Hospital Provider Class
2008-2010 Outpatient Payments by Type of Service

Type of Service	Two-year average rate of change Payments Per 1000 Members	Services Per 1000 Members	Payment Per Service	Three-year Payout	% of Total Payout
Surgery	-21.4%	16.3%	-107.6%	$ 223,056,754	42.1%
Laboratory/Pathology	30.7%	28.1%	-33.5%	$ 82,170,518	15.5%
Diagnostic X-Ray	14.5%	9.5%	-86.0%	$ 99,426,294	18.8%
Outpat Med Emergency, Non-Accid	25.6%	14.9%	13.1%	$ 59,207,679	11.2%
Chemotherapy	20.8%	81.1%	104.8%	$ 30,933,533	5.8%
Physical Therapy	8.1%	16.8%	-50.5%	$ 28,352,118	5.4%
Outpat Med Emergency, Accident	54.4%	26.3%	-17969.5%	$ 14,330,380	2.7%
Therapeutic X-Ray	17.8%	20.8%	-271.2%	$ 23,311,149	4.4%
Maternity	16.0%	24.5%	3.6%	$ 7,363,207	1.4%
All Others	-114.8%	-20.4%	-33.0%	$ (38,438,979)	-7.3%
Total	**-2.1%**	**5.8%**	**-7.2%**	**$ 529,712,653**	**100.0%**



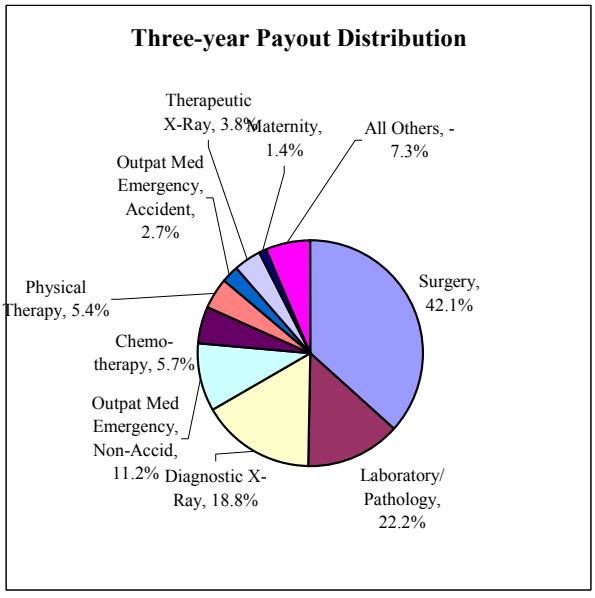


Table 5 shows that surgery, laboratory/pathology and diagnostic radiology accounted for 76 percent of total outpatient payments. In many respects, these top three types of service are used in conjunction with one another to enhance patient care. For example, many times, surgical procedures are coupled with laboratory/pathology services as physicians order a variety of blood and imaging tests to diagnose and subsequently treat a presented illness.

As reviewed in the prior sections, the Traditional hospital membership is an older and potentially less healthy population. The outpatient diagnoses for this population included cancer diagnoses and screenings, cardiovascular screenings and conditions, atrial fibrillation and coronary atherosclerosis, obstructive sleep apnea, kidney stones and abdominal pain. These conditions were recurring themes throughout analysis of the hospital cost section from the broadly defined type of service categories to the detailed diagnostic code descriptions.

Outpatient Cost by Major Diagnostic Category

Table 8
Hospital Provider Class
2008-2010 Outpatient Payments by Major Diagnostic Category

Outpatient Hospital by Major Diagnostic Category	Two year average rate of change Per 1000 Members			2008-2010 Payments	2008-2010 Visits	Avg Pmt/Vst	Pct of Total	
	Payments	Visits	Pmt/Vst				Payout	Days
Nervous System	-2.0%	14.2%	-13.9%	$ 20,787,495	355,958	$ 58	3.9%	2.9%
Disease of the Eye	-10.0%	5.8%	-14.3%	$ 8,625,121	105,077	$ 82	1.6%	0.9%
Disease of ENT	-11.3%	-3.3%	-8.3%	$ 20,605,218	442,973	$ 47	3.9%	3.7%
Respiratory System	-4.3%	-0.7%	-2.8%	$ 38,879,430	911,763	$ 43	7.3%	7.5%
Circulatory System	7.2%	14.0%	-5.9%	$ 48,295,124	850,047	$ 57	9.1%	7.0%
Digestive System	-5.2%	0.7%	-5.4%	$ 55,557,690	1,682,937	$ 33	10.5%	13.9%
Hepatobiliary Sys/Pancreas	-2.8%	4.7%	-5.8%	$ 12,446,250	311,217	$ 40	2.3%	2.6%
Musculorskeletal	-4.3%	7.6%	-10.8%	$ 95,590,557	1,721,613	$ 56	18.0%	14.2%
Skin & Subcutaneous Disease	-3.0%	6.0%	-8.5%	$ 38,577,597	739,366	$ 52	7.3%	6.1%
Nutritional Disease	-15.4%	2.9%	-17.7%	$ 18,562,452	903,831	$ 21	3.5%	7.5%
Kidney/Urinary Tract	-7.8%	1.5%	-8.4%	$ 26,483,976	770,908	$ 34	5.0%	6.4%
Male Reproductive Sys	-1.4%	10.5%	-10.6%	$ 9,660,490	133,713	$ 72	1.8%	1.1%
Female Reproductive Sys	-12.4%	-1.6%	-10.6%	$ 18,329,095	440,737	$ 42	3.5%	3.6%
Pregnancy	-13.0%	-10.1%	-3.1%	$ 3,901,367	96,286	$ 41	0.7%	0.8%
Newborns in Perinatal Period	-19.1%	6.9%	-24.2%	$ 161,634	3,229	$ 50	0.0%	0.0%
Disease of the Blood	-5.5%	6.6%	-11.6%	$ 10,838,385	427,634	$ 25	2.0%	3.5%
Neoplasms	13.9%	6.6%	6.6%	$ 21,096,373	376,724	$ 56	4.0%	3.1%
Infectious Disease	-11.3%	7.7%	-16.3%	$ 2,205,040	100,079	$ 22	0.4%	0.8%
Mental Disorders	-4.6%	-3.1%	-1.3%	$ 2,201,528	58,649	$ 38	0.4%	0.5%
Alcohol/Drug Abuse	-12.3%	-11.5%	-0.8%	$ 719,505	24,371	$ 30	0.1%	0.2%
Injury Poisoning	-8.9%	6.0%	-13.0%	$ 4,015,744	77,841	$ 52	0.8%	0.6%
Burns	-22.6%	-13.7%	-10.5%	$ 256,817	3,236	$ 79	0.0%	0.0%
Factors Influencing Health Status	8.9%	17.9%	-7.6%	$ 65,566,903	1,533,458	$ 43	12.4%	12.6%
Human Immunodeficiency Virus Infections	-20.9%	-3.2%	-19.4%	$ 200,912	5,827	$ 34	0.0%	0.0%
Other	-7.2%	-13.0%	5.6%	$ 389,381	9,145	$ 43	0.1%	0.1%
Unknown	27.0%	37.2%	-5.8%	$ 5,758,566	39,372	$ 146	1.1%	0.3%
Total	**-2.1%**	**5.8%**	**-7.2%**	**$ 529,712,653**	**12,125,991**	**$ 44**	**100.0%**	**100.0%**

Table 8 shows the distribution of hospital outpatient costs, utilization and price by major diagnostic category. The majority of the categories experienced average payment per member decreases.

Diseases of the musculoskeletal system had the highest three year payout, almost $96 million and accounted for 18 percent of the total payout, as well as 14.2 percent of the total days. Even though musculoskeletal conditions had the highest three year payout, the payments per 1000 members decreased 4.3 percent as a result of a 10.8 percent decrease in the average payment per visit, indicating a less severe illness mix. Interesting to note, utilization for this MDC increased 7.6 percent and was a significant factor in 2010 and to a lesser extent in 2009 (Appendix C). Musculoskeletal conditions include back pain, joint pain, arthritic disorders and sprains and tears which are all conditions associated with physical activity and/or aging. An estimated 40 million Americans have some form of arthritis or other rheumatic condition. That number is expected to

climb to 59.4 million, or 18.2 percent of the population, by the year 2020, according to a new report published as a collaborative effort between the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Arthritis Foundation, and the American College of Rheumatology. This increase is largely due to the aging of the U.S. population.[23]

Digestive disorders ranked second in terms of total payout (10.5 percent) and also experienced an average decrease in payments per 1000 members of 5.2 percent primarily due to decreased price, indicating a less severe illness burden. The most common diagnoses by payment were abdominal pain, hernia and colon disorders and cancer. These are all conditions that may be impacted by a member's diet, weight, level of stress and lifestyle choices.

[23]http://www.nih.gov/news/pr/may98/niams-05.htm

Top 50 Diagnosis

Table 9
Hospital Provider Class
2008-2010 Outpatient Payments by Top 50 Diagnoses

Outpatient Hospital by Top 50 Diagnoses	Two year average rate of change Per 1000 Members			2008-2010 Payments	2008-2010 Visits	Avg Pmt/Vst	% of Total Payout
	Payments	Visits	Pmt/Vst				
Antineoplastic Chemo Enc	64.4%	33.1%	20.7%	$ 9,586,674	3,308	$ 2,898	1.8%
Crnry Athrscl Natve Vssl	20.4%	8.4%	12.1%	$ 12,534,403	3,929	$ 3,190	2.4%
Other And Unspecified Hyperlipidemia	-17.5%	6.1%	-22.5%	$ 2,416,307	37,413	$ 65	0.5%
Abdmnal Pain Unspcf Site	-6.8%	8.1%	-13.8%	$ 4,193,188	11,542	$ 363	0.8%
Other Chest Pain	5.0%	9.1%	-3.8%	$ 7,578,353	4,505	$ 1,682	1.4%
Routine General Medical Examination A	1921.1%	257.4%	393.4%	$ 3,860,624	12,552	$ 308	0.7%
Unspecified Chest Pain	-6.3%	2.4%	-8.3%	$ 8,371,335	8,780	$ 953	1.6%
Malignant Neoplasm Of Breast (Female),	12.4%	7.8%	4.8%	$ 8,987,651	10,173	$ 883	1.7%
Dmii Wo Cmp Nt St Uncntr	-17.2%	0.7%	-18.5%	$ 2,092,670	26,718	$ 78	0.4%
Screen Mammogram Nec	15.4%	7.3%	7.6%	$ 8,554,880	56,742	$ 151	1.6%
Unspecified Essential Hypertension	-15.7%	3.9%	-18.9%	$ 2,758,915	22,054	$ 125	0.5%
Unspecified Anemia	-8.9%	9.1%	-17.3%	$ 1,552,752	13,398	$ 116	0.3%
Malaise And Fatigue Nec	-3.1%	15.6%	-16.8%	$ 1,511,251	12,680	$ 119	0.3%
Pure Hypercholesterolemia	-19.9%	2.8%	-22.7%	$ 1,032,719	17,097	$ 60	0.2%
Urinary Tract Infection, Site Not Specifie	-8.4%	11.1%	-17.4%	$ 1,582,619	18,485	$ 86	0.3%
Atrial Fibrillation	88.4%	-1.4%	88.3%	$ 4,902,099	15,491	$ 316	0.9%
Unspecified Iron Deficiency Anemia	8.5%	21.1%	-10.4%	$ 459,689	2,104	$ 218	0.1%
Rheumatoid Arthritis	33.6%	9.2%	21.3%	$ 2,761,390	5,249	$ 526	0.5%
Unspecified Hypothyroidism	-17.4%	7.5%	-23.7%	$ 1,224,243	17,640	$ 69	0.2%
Headache	36.7%	35.1%	-0.1%	$ 3,075,978	4,833	$ 636	0.6%
Abdmnal Pain Oth Spcf St	-0.5%	11.9%	-11.1%	$ 2,246,903	2,939	$ 765	0.4%
Multiple Sclerosis	10.8%	9.3%	2.0%	$ 1,535,179	1,633	$ 940	0.3%
Other Diseases Of Lung, Not Elsewhere C	-6.7%	-2.2%	-4.4%	$ 1,875,385	2,653	$ 707	0.4%
Rotator Cuff (Capsule) Sprain And Strain	-0.8%	2.9%	-3.4%	$ 2,248,725	1,369	$ 1,643	0.4%
Carbuncle And Furuncle Of Trunk	400.9%	255.9%	41.9%	$ 16,697	70	$ 239	0.0%
Calculus Of Kidney	11.6%	11.3%	-0.2%	$ 3,936,763	5,062	$ 778	0.7%
Calculus Of Ureter	6.1%	12.6%	-6.1%	$ 3,738,395	2,134	$ 1,752	0.7%
Screening For Malignant Neoplasm Of T	1.2%	6.3%	-5.1%	$ 1,989,327	35,432	$ 56	0.4%
Chemotherapy Follow-Up Examination	739.2%	213.5%	145.9%	$ 1,291,980	537	$ 2,406	0.2%
Malignant Neoplasm Of Prostate	5.2%	2.9%	2.4%	$ 6,954,398	5,956	$ 1,168	1.3%
Malignant Neoplasm Of Bronchus And L	5.9%	-2.9%	8.9%	$ 2,942,962	2,982	$ 987	0.6%
Unspecified Disorders Of Bursae And Te	-7.2%	7.7%	-13.6%	$ 2,145,975	1,448	$ 1,482	0.4%
Oth Lymp Unsp Xtrndl Org	29838.3%	17589.0%	19.7%	$ 2,129,885	1,888	$ 1,128	0.4%
Hematuria, Unspecified	94.5%	168.9%	-22.5%	$ 719,041	3,306	$ 217	0.1%
Special Screening For Malignant Neoplas	-5.5%	-5.7%	1.0%	$ 3,906,125	6,356	$ 615	0.7%
End Stage Renal Disease	-17.8%	0.7%	-20.7%	$ 1,871,251	675	$ 2,772	0.4%
Malignant Neoplasm Of Colon, Unspecif	-1.1%	-4.5%	-0.7%	$ 1,768,855	1,546	$ 1,144	0.3%
Abdmnal Pain Rt Lwr Quad	-2.7%	5.6%	-7.8%	$ 1,260,807	1,418	$ 889	0.2%
React-Cardiac Dev/Graft	-11.9%	132.4%	-51.8%	$ 44,846	75	$ 598	0.0%
Calculus Of Gallbladder With Other Cho	-4.6%	1.5%	-6.4%	$ 2,605,987	723	$ 3,604	0.5%
Lumbago	-7.8%	7.4%	-14.3%	$ 5,000,683	8,835	$ 566	0.9%
Malignant Neoplasm Of Rectum	147.7%	58.2%	44.0%	$ 866,520	687	$ 1,261	0.2%
Malignant Neoplasm Of Other Specified	19.2%	26.7%	-6.2%	$ 3,055,266	3,144	$ 972	0.6%
Essential Hypertension, Benign	-13.8%	15.3%	-25.4%	$ 526,677	7,602	$ 69	0.1%
Pain In Soft Tissues Of Limb	-1.3%	4.7%	-5.7%	$ 2,178,817	7,184	$ 303	0.4%
Regional Enteritis Of Unspecified Site	15.6%	12.9%	0.1%	$ 2,001,858	1,754	$ 1,141	0.4%
Diarrhea	-4.0%	10.8%	-13.6%	$ 929,504	4,577	$ 203	0.2%
Inguinal Hernia Without Mention Of Obs	1.8%	3.9%	-3.7%	$ 1,887,962	931	$ 2,028	0.4%
Benign Neoplasm Of Colon	-12.0%	-6.9%	-5.9%	$ 3,200,319	4,475	$ 715	0.6%
Excessive Or Frequent Menstruation	4.7%	12.1%	-9.3%	$ 1,810,392	2,254	$ 803	0.3%
Top 50 Total	10.0%	10.4%	-0.5%	$ 155,725,223	424,338	$ 367	29.4%
GRAND TOTAL	**-2.1%**	**5.8%**	**-7.2%**	**$ 529,712,653**	**12,125,991**	**$ 44**	**100.0%**

As shown in Table 9, the top 50 diagnoses represented almost $156 million or 29.4 percent of total outpatient payments. Overall, outpatient payments for the top 50 diagnosis codes increased 6.2 percent, due to a 9.3 percent increase in the average number of visits partially offset by a 3.2 percent decrease in the average price per visit. The highest ranking by payout was for chest pain/angina, a circulatory condition. The average payment increase per 1000 members for this service was 20.4 percent due to an average increase in use of 8.4 percent and a rise in price of 12.1 percent. Circulatory disorders include conditions such as chest pain, coronary artherosclerosis, atrial fibrillation and hypertension.

Cost Containment Programs

The health care industry has responded to the increased prevalence of chronic disease by developing more sophisticated ways to target and engage members in chronic condition management programs as a means of controlling cost. BCBSM has expanded its scope of medical care management design to include integrated member-centric programs and no longer directs all of its attention to provider costs and provider utilization. Highlights of BCBSM's cost containment programs are described below:

Member-focused Health Management

BlueHealthConnection®

BlueHealthConnection® provides total health engagement by driving healthy behaviors, better outcomes, and lower costs. The state of the art wellness and care management programs within BlueHealthConnection support the health of BCBSM members across the continuum of care. With BlueHealthConnection, BCBSM has gone beyond traditional chronic condition disease management and has built a wide range of programs to support a whole-person approach to care management.

Members have access to a variety of programs and educational resources to help them make appropriate health care decisions and improve or maintain their health. The online health portal, accessed through bcbsm.com, contains a robust suite of health resources. An industry-leading online questionnaire, the Succeed™ Health Assessment (HA), is designed to assess health behaviors and help members pinpoint specific health issues and risks. Upon completion of the HA, members receive a personalized plan for success and recommendations for digital health coaching programs available through bcbsm.com.

BlueHealthConnection also provides industry-leading programs to support members managing chronic and complex medical conditions. A state-of-the-art predictive model is utilized to identify members at risk for specific medical conditions. Through case management, registered nurse case managers provide assistance to members with complex medical conditions by helping them understand treatment options, transition from the hospital to home, and advocate for the appropriate care setting for recommended services. BCBSM registered nurses also work, over the phone, with members who have chronic conditions. Through a series of calls, members are empowered to better understand how to self-manage their condition and improve their health.

BlueHealthConnection programs allow BCBSM to become a health care partner and single source for health management information for members.

The BCBSM BlueHealthConnection Satisfaction Survey is an annual survey used to measure users' overall satisfaction with BlueHealthConnection. In 2010, overall satisfaction with BlueHealthConnection remained high (94% satisfaction). Key findings from the survey showed patient satisfaction with BCBSM's BlueHealthConnection was very positive. In addition:

♦ Greater than 95% of respondents indicated that the program helped them set goals to manage their health care needs for the Chronic Condition Management (98.1%), Case Management (95.1%), and Wellness Coaching (95.1%) programs.

♦ Over 98% of respondents indicated that their case manager answered their questions and helped with their concerns - Chronic Condition Management (98.1%) and Case Management (99%).

♦ Most members believed that the Wellness and Care Management program helped them to make lifestyles changes or health decisions - Chronic Condition Management (98.1%), Wellness Coaching (97.9%), Targeted Outreach (100%), 24/7 Nurse line (94.1%).

♦ More than 9 out of 10 respondents said that their nurse helped them understand when to call their doctor - Care Transitions To Home (92.1%), Chronic Condition Management (98.8%), Case Management (95%).

♦ Nearly 90% of respondents indicated that they were satisfied with the Quit the Nic program, and 100% of those members indicated that their health coach was courteous and that they would participate in the program again.

BlueHealthConnection members receive a variety of communications from their employer group and BCBSM promoting programs they are eligible to participate in. Providers are also informed of BlueHealthConnection resources available to their BCBSM patients through articles published in the Record and information updates provided on web-DENIS.

Social Mission

The goal of BCBSM's social mission is to help Michigan residents be healthier, and consequently reduce health care costs. Social mission programs address health issues with serious and sometimes fatal consequences that, in many cases, are preventable. During the reporting period, BCBSM continued previous programs that targeted domestic violence, smoking, depression, physical activity and healthy weight. BCBSM recognizes the importance of these programs in addressing risk factors underlying the chronic diseases many Michigan residents face.

Provider-Focused Use Management

BCBSM's member and provider, "pre-authorization" programs effectively assure the appropriateness of setting and medical necessity of recommended treatment plans. These pre-authorization programs also provide "real-time" information that can be integrated with care

management to identify and target members currently facing health care decisions. BCBSM's precertification efforts include a review of a patient's symptoms and proposed treatment to determine, in advance, whether they meet BCBSM criteria for inpatient treatment.

For Michigan-based hospitals, the provider is required to apply InterQual criteria to certify the case for the inpatient setting. InterQual is an automated Clinical Decision Support Criteria system used to identify intensity of service and severity of illness and screen proposed medical care based on patient-specific, best medical care processes. The facility provides a "prenotification" of the admission through an online process and asserts that the admission meets the applicable criteria. This information is not only used to validate the admission (and is auditable as part of our retrospective review processes), but also integrates key "real time" information on hospital admissions for use in BCBSM's care management programs, particularly case management. For non-DRG hospitals, pre-certification also verifies that the appropriate length of stay is assigned for elective, emergency, or maternity admissions. For DRG hospitals, appropriateness of setting is verified. For out of state hospitals, a telephonic prenotification process is deployed.

BCBSM continues its vigilance through a series of retrospective approaches to utilization management. Post care medical record audits for both utilization and financial perspective are deployed, assuring that appropriate billing practices were applied (and recovering payments when that is found not to be the case). In some cases, where providers have shown a pattern of utilization concern, prepayment utilization review restricts billing privileges.

BCBSM's efforts in other programs also contribute to managing utilization. An example is BCBSM's medical policy decisions about which procedures to cover. BCBSM deploys a very robust medical policy approach that uses claims system commands that prevent payment of non-covered services to avoid having to recover inappropriate payments. Claims edits not only prevent payment of customer-designed benefit restrictions administered by BCBSM, but also assure that medical policy rules (which define clinical appropriateness of care) are met.

Provider-Focused Quality Management

BCBSM's quality management programs reassure groups and members that BCBSM selects and retains providers of the highest quality and collaborates with them to encourage using evidence-based care practices and safety in the health care setting.

BCBSM is improving health care in Michigan through its Value Partnerships programs, a collection of clinically oriented initiatives among Michigan physicians, hospitals and Blue Cross Blue Shield of Michigan that are significantly improving the quality of patient care across Michigan.

Through collaboration and data sharing, the initiatives are enhancing clinical quality, decreasing complications, managing costs, eliminating errors and improving health outcomes. Here are some examples:

- Saved more than $65 million in three years through the appropriate use of high- and low-tech radiology services
- Reduced complications following bariatric surgery by 24 percent
- Reduced radiation exposure by 53 percent for patients undergoing cardiac CT angiography — with no reduction in image quality

Membership

During this reporting period, membership decreased by almost 20 percent or approximately 30,000 members. The ratio of patients to members decreased in 2010 (3.0 percent) after experiencing an increase in 2009 of 3.5 percent. Reasons behind declining membership include Traditional members moving to managed care or the PPO product, members losing health benefits through their employers, work force reductions, aggressive competitor pricing and a declining economy.

As shown in Charts 4A and 4B Traditional membership has declined in each age category except for the 46-64 and greater than 65 years age bands. Not surprisingly, this age had the most significant impact on costs and it accounted for more than 45 percent of the total payout.

The age group of 46-64 represents 40 percent of the 2010 Traditional hospital membership, while it accounted for 26 percent of the Michigan population.

Chart 4A
2008 Traditional Membership by Age

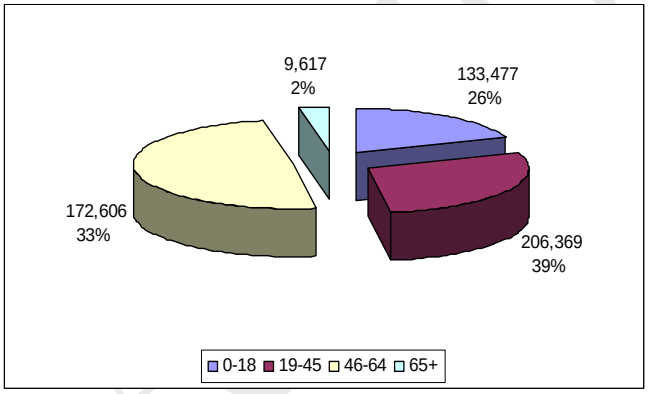
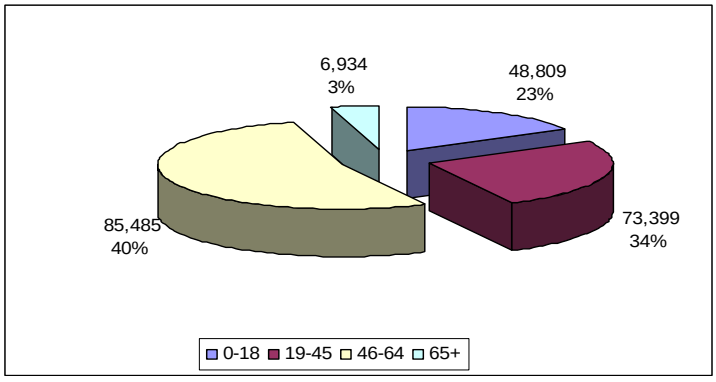


Chart 4B
2010 Traditional Membership by Age



ACCESS GOAL PERFORMANCE

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

PA 350 Access Objectives

Objectives

- Provide direct reimbursement to participating providers that render medically necessary, high-quality services to BCBSM members
- Communicate with participating providers about coverage determinations, billing, benefits, provider appeals processes, BCBSM's record keeping requirements and the participating agreement and its administration
- Maintain and periodically update a printed or website directory of participating providers

Performance - Access Goal and Objectives

Formal participation rates are derived by comparing the number of formally participating providers to the number of total licensed providers. As shown in Table 8 below, BCBSM maintained a 100 percent participation rate with hospitals in all regions of the state. The number of participating hospitals did not change between 2009 and 2010.

Table 8
2009 – 2010 Hospital Access by Region

	2010			2009		
Region	Number of Participating Providers	Total Providers	Participation Rate	Number of Participating Providers	Total Providers	Participation Rate
1	48	48	100%	48	48	100%
2	9	9	100%	9	9	100%
3	8	8	100%	8	8	100%
4	6	6	100%	6	6	100%
5	19	19	100%	19	19	100%
6	20	20	100%	20	20	100%
7	18	18	100%	18	18	100%
8	14	14	100%	14	14	100%
9	14	14	100%	14	14	100%
Ohio Hospitals	2	2	100%	2	2	100%
Statewide	158	158	100%	158	158	100%

Chart 5 on page 31 provides a regional map defining the PA 350 regions and showing the 2010 distribution of participating hospitals by county. Below are main factors that helped achieve the access goal, which are highlighted in this section:

- BCBSM's reimbursement methodology
- Provider communication via BCBSM publications, online assistant tools, and provider consultants
- BCBSM hospital satisfaction studies and programs

Provider Communications

Enhanced channels of communication helped establish and maintain a good rapport with participating providers. Satisfaction surveys have confirmed that communication is important to hospitals in doing business with BCBSM.

Publications and Services

During this reporting period, all providers received BCBSM's monthly newsletter, *The Record*, which communicates important, current information pertinent to the timely and efficient servicing of BCBSM members including billing, reimbursement, policy changes, group-specific benefit changes and other provider-specific information. *The Record* was created with input from provider focus groups in an ongoing effort to improve communications with providers and to make BCBSM information more accessible to them.

Hospitals received *Hospital Update*, a bimonthly publication for hospital leadership that highlights BCBSM initiatives to solve problems and improve patient care and day-to-day business transactions. Hospitals also received *Physician Update*, a monthly newsletter from BCBSM's corporate medical director. This publication provided executive summaries of important topics of interest and BCBSM programs to physicians and hospital executives.

Participating hospital providers can access a comprehensive online provider manual on web-DENIS, which contains detailed instructions for servicing BCBSM members. The manual is updated as necessary allowing hospitals to obtain information on a real time basis.

BCBSM's Provider Consulting Services increased provider satisfaction by building relationships through enhanced visibility, communication and consultative services. Provider consultants advocate for the priority and resolution of issues identified by providers to assure their needs are communicated to and acted upon by BCBSM.

BCBSM members have easy access to provider directories by going to the bcbsm.com home page and following the directions to search for a provider in their local area.

Inquiry Systems

Web-DENIS offers BCBSM providers an Internet-based program via a secured provider portal on www.bcbsm.com. This program provides a quick delivery of contract eligibility, claims status, online manuals, newsletters, fee schedules, medical and benefit policy information for any procedure or revenue code, reports and much more information needed to make doing business with BCBSM easier over the web.

BCBSM continues to enhance web-DENIS capabilities. During 2008, BCBSM introduced a new search tool, Explainer, to web-DENIS. Explainer offers more information than the previous search tool and includes medical, benefit and payment policy information. Payment policy information provides member cost-sharing and dollar maximums with detail available at the procedure and revenue code levels for selected time periods. BCBSM simplified web-DENIS by standardizing the look of the screens for members' claims processed on the local and NASCO claims systems. In 2009, Web-DENIS added new claims tracking and screen printing capabilities. Information on members' other active coverage is now included with BCBSM eligibility information.

CAREN+, an integrated voice response system, is another avenue that providers can use to obtain information on eligibility, benefits, deductibles and copayments. CAREN+ will transfer the caller directly to a service representative if they say "representative." Several enhancements were made to CAREN+ to speed up inquiries and improve privacy. For example, protected health information can be keyed in using the telephone keypad to prevent other patients from overhearing information verbally told to CAREN+. The system repeats the information back to the caller to verify accuracy.

BCBSM's ongoing communication with providers enhanced relationships with them and maintained formal participation.

Reimbursement

BCBSM's reimbursement methodology was also important in maintaining participation levels.

Peer Groups 1 through 4

Peer groups 1 through 4 include large and medium sized acute care general hospitals. For these hospitals, inpatient services are price-based using Medicare's diagnostic related groupings (DRGs) classification system. An individual hospital is reimbursed the lesser of the billed charge or the DRG specific price. Annual updates are determined based on the National Hospital Input Price Index with adjustment. The update process is described in Section IV, Exhibit B of the PHA.

BCBSM's reimbursement for outpatient laboratory, radiology, surgery, physical therapy, occupational therapy and speech therapy is price-based. The remaining outpatient services are reimbursed on an outpatient payment-to-charge ratio basis, until such time that they can be priced.

Peer Group 5

Peer group 5 consists of small rural hospitals that are reimbursed controlled charges for both inpatient and outpatient services. The annual update for Peer Group 5 hospitals is the same as non-Peer-Group 5 hospitals.

Peer Groups 6 and 7

Peer groups 6 and 7 consist of psychiatric and rehabilitation hospitals and Medicare-exempt psychiatric and rehabilitation units of acute care hospitals. Reimbursement for inpatient services are on a per diem basis. Reimbursement is the lesser of the billed charge or per diem payment.

Annual updates and outpatient services reimbursement are the same as described in peer groups 1 though 4 hospitals.

Non-Acute Services

Other hospital-based non-acute services that can be provided under another provider class plan such as, but not limited to, residential substance abuse, home health care agencies, and skilled nursing facilities will be reimbursed using a hospital-specific payment-to-charge ratio set at a level not to exceed 1.0.

BCBSM may require that these services be considered "freestanding" and that they be reimbursed under a separate agreement.

Alternative Reimbursement Arrangements

BCBSM may consider alternative reimbursement methodologies such as "bundled" or "fixed" price arrangements covering all services per episode of care, where the reimbursement methodologies in this plan are not appropriate for payment of certain services, such as bone marrow transplants. All such alternative reimbursement methodologies will be determined through the contract administration process.

Hospital Satisfaction Studies and Programs

BCBSM conducts annual surveys as a continued commitment to enhancing relationships with hospitals. The surveys measure overall satisfaction in doing business with BCBSM and several key elements such as service, claims processing and online tools. BCBSM uses the responses to assess what is working well and where opportunities for improvement exist. The goal of the survey process is to identify ways to make it easier for hospitals to do business with BCBSM.

Survey Results

BCBSM conducted a Hospital CEO satisfaction survey in January 2010. The survey focused on executive relationships and interactions with BCBSM. The results showed as much good news and positive responses as they revealed opportunities for improvement. Some of the areas earning high marks included having a positive overall relationship with BCBSM, receiving quality service from BCBSM and believing that BCBSM is the health care improvement leader

in Michigan. Some opportunities for improvement included the contracting process, reimbursement model, and communication regarding reimbursement, health care reform and BCBSM's future direction.

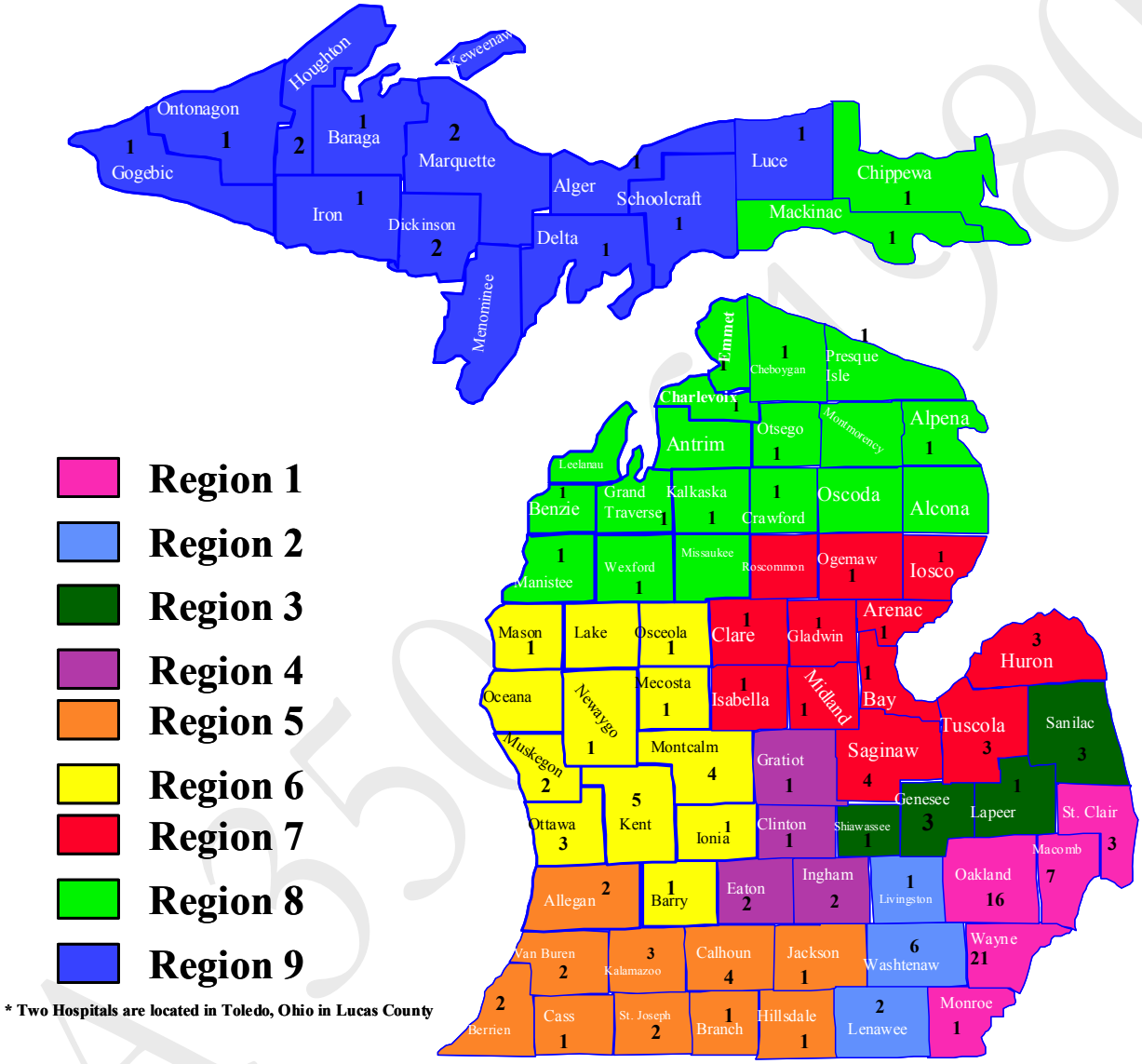
In February 2010, a satisfaction survey was conducted with BCBSM hospital patient account managers. The intent of the survey was to evaluate their perceptions of how easy it was to do business with BCBSM compared to other insurers. The survey showed that overall satisfaction with BCBSM, provider inquiry, and provider consultant services was high. Areas identified for continuous improvement based on their overall impact on satisfaction were communication, provider inquiry, provider consultant services and claims processing.

Touchpoint Measures

The Blue Cross Blue Shield Association Member Touchpoint Measures (MTM) Program assesses operational and service performance of all BCBS Plans by measuring on a quarterly basis, the accuracy of the subscriber-level enrollment process so that claims and bills are processed correctly; customer service representatives answer inquiries promptly and correctly; customers and providers receive correct benefit and eligibility information; and the subscriber has access to all benefits and network providers. BCBSM's MTM scores have progressed steadily over the past few years when compared to the 55 other Blue plans. In first quarter 2011, BCBSM reported earning a 100 percent score in the BCBSA's MTM program in fourth quarter 2010, the third straight quarter for a perfect score.

Also, in 2010, BCBSA added two new MTM metrics to the program: First Call Resolution and Blue Experience Metric. First Call Resolution tracks a plan's ability to resolve a customer's issue with just one call. Blue Experience Metric captures the "voice of the customer". In particular, it focuses on a customer's experience related to wellness programs, customer service, claims payment, provider/network access and member education.

Hospital Provider Class
Distribution of Participating Hospitals by County
Chart 5



*** Two Hospitals are located in Toledo, Ohio in Lucas County**

QUALITY OF CARE GOAL PEFORMANCE

"Providers will meet and abide by reasonable standards of health care quality."

PA 350 Quality Objectives

Objectives

- Ensure BCBSM members receive quality care by requiring participating providers to meet BCBSM's qualification and performance standards
- Obtain continuous input from hospital through the Contract Administration Process
- Meet with provider organizations such as Michigan Health and Hospital Association to discuss issues of interest and concern
- Maintain and update, as necessary, an appeals process that allows participating providers to appeal reimbursement policies disputes or disputes regarding utilization review audits

Performance on Quality of Care Goal and Objectives

BCBSM's approach to achieving the quality of care objectives for the hospital provider class was to:

- Ensure quality of care by enforcing qualification standards for participation
- Maintain quality controls through utilization management and audits
- Implement quality management initiatives that promote safety, improve the health of the community and ensure the delivery of high quality health care
- Develop strong relationships with participating providers by offering them various avenues to receive information and to voice concerns

Qualification Standards

BCBSM offers all short-term general acute care hospitals, short-term psychiatric care hospitals, and intensive rehabilitation programs the opportunity to participate providing they meet BCBSM's qualification standards. Hospitals must be licensed by the state of Michigan, comply with federal government standards (e.g., Medicare certification), have appropriate accreditation and comply with the Certificate of Need requirements of the Michigan Public Health Code. The specifics of these requirements and additional qualification standards are listed in the Hospital Provider Class Plan and Exhibit A of the PHA.

Quality and Use Management Tools

Utilization Management

BCBSM uses an admission precertification process to manage inpatient utilization and provide interventions that ensure members receive appropriate, high quality and cost-effective care.

Prenotification and Precertification of Admissions

Prenotification is an electronic process that allows participating hospitals to notify BCBSM of inpatient admissions using web-DENIS. Timely prenotification allows BCBSM to quickly identify cases for potential intervention by BCBSM care management programs.

Precertification of admissions ensures that the inpatient setting is medically appropriate for the patient's condition and level of care. Precertification is a telephonic process and is only required of hospitals when admissions do not meet InterQual criteria or the admission is not eligible for prenotification. Admissions for routine maternity, psychiatric care, substance abuse treatment, rehabilitation therapy, observation stays, and admissions in hospital peer groups 6 and 7 are not eligible for prenotification and must be precertified.

Audits

During utilization review audits paid claims data and the corresponding medical records are reviewed to ensure that admissions to the hospitals and outpatient services were appropriate and the services rendered were performed for the appropriate indications, in appropriate settings and that services were accurately billed and paid. Providers are selected for audit based on a number of factors, including:

- Random selection
- Prior audit history
- Referrals from internal or external sources
- Last audit occurred over a year ago

At the conclusion of an audit, a departure conference with the facility representative provides preliminary findings identified during the audit. The departure conference also serves as an opportunity for education. Methods to enhance correct coding and billing practices are discussed and facilities are encouraged to build on existing strengths. As a result, performance can and should immediately improve.

Within six weeks, the facility receives a letter detailing the final results of the audit. This letter identifies individual problem cases (e.g., diagnosis errors, billing errors, inappropriate settings, coding errors and incorrect DRG selection), problem patterns, and any refunds due BCBSM. The letter also specifies related corrective actions. Finally, the letter describes the appeals process available to providers who disagree with BCBSM audit findings. BCBSM conducts a variety of audits that review hospital performance for medical appropriateness, appropriateness of setting and compliance with benefits and billing requirements. Routine auditing functions include the following types of audits:

Medical Necessity Review

Reviews for medical necessity verify that the care and treatment are appropriate for the symptoms and consistent with the diagnosis. BCBSM verifies that the type, level and length of care and the setting are necessary to provide safe and appropriate care based on InterQual criteria for inpatient care.

DRG Validation Reviews

DRG validation audits were conducted for hospitals in Peer Groups 1 through 4 to verify the accuracy of ICD-9-CM codes, diagnoses and procedures from medical records and the DRG assigned by BCBSM. All hospitals in Peer Groups 1-4 are reviewed each year.

Readmission Case Reviews

Readmission audits identify admissions that occur within 14 days of a previous discharge that should be combined resulting in a single DRG payment because the patient was either:

- discharged prematurely necessitating an unplanned hospital readmission
- the subsequent admission was planned without a medical reason for the delay in services, or
- the readmission is for continued care and services rendered during the previous admission

Catastrophic Case Reviews

Catastrophic cases are subject to review and recovery of over payments. A case is defined as catastrophic if its calculated cost exceeds the DRG payment by at least $30,000. Payment for catastrophic cases is 75 percent of the excess cost. The cost is determined by applying the hospital-specific cost-to-charge ratio to covered charges. Catastrophic case reviews are performed on peer group 1 through 4 hospitals, which are reimbursed for inpatient admissions based on DRGs.

Hospital Outpatient Audits

Hospital outpatient audits are conducted to verify that services billed are covered, ordered by a physician and have a documented result, billed correctly with appropriate procedure codes, diagnosis codes and revenue codes and to determine whether services were medically appropriate. Services reviewed include, but are not limited to observation beds, cardiac rehabilitation, laboratory, radiology, physical therapy, occupational therapy, speech and language pathology services, high-dollar services, emergency room services and outpatient surgery. The review focuses on verifying that services billed and paid are benefits under the member's contract and that the services billed match the services that were ordered and performed.

Transfer Audits

Transfers between hospitals may result in overpayments when facilities bill the incorrect discharge status for patients who were transferred to another acute care facility. BCBSM conducts transfer audits in order to determine whether facilities are billing correctly for this service.

Financial Investigations

Our Corporate and Financial Investigations department follows up on reports of improper activity by patients and providers and, if improper activity is substantiated, refers information for possible legal action. CFI reviews information from a number of different sources to determine when an investigation is necessary.

Provider Appeals Process

In accordance with sections 402(1), 403 and 404 of PA 350, BCBSM makes a formal appeals process available to hospitals. A description of the process can be found in Exhibit D of the PHA. The appeals process is available to providers that disagree with BCBSM determinations as the result of audit findings. Hospitals are informed of the appeals process through *The Record*, the online provider manual, and the PHA. Hospitals are again made aware of the appeals process during utilization review audits.

Details of audit activity for the reporting period are provided in Appendix E of this report:

Quality Management Initiatives

BCBSM continues its commitment to "best in class" quality management through several innovative programs geared to improve the quality of care.

Hospital Pay for Performance Program

BCBSM has two hospital pay-for-performance programs. One program is designed for large and medium-sized acute care hospitals This program gives top performing hospitals in peer groups 1-4 the opportunity to earn up to an additional five percent on their inpatient and outpatient operating payments if they met specific performance thresholds. The other program is designed specifically for small rural hospitals. This program determines six percentage points of reimbursement for peer group 5 hospitals.

The amount a hospital earned, based on its 2010 performance, was reflected in its BCBSM payments beginning July 1, 2011.

Prequalifying Conditions

In 2010, hospitals were required to meet the following three pre-qualifying conditions to participate in the P4P program:

1. Publicly report performance on all applicable quality indicators to the Hospital Quality Alliance, for publication on the CMS Hospital Compare website. This condition was applicable to the entire program. If a hospital failed to meet this condition, it forfeited its eligibility for the entire P4P program.

2. Demonstrate an active commitment to patient safety. The specific requirements of this prequalifying condition are described in Attachment A of the 2010 P4P program document.

   This prequalifying condition applied only to the quality indicator measures of the program. If a hospital failed to meet this condition it forfeited its eligibility for payment for the quality indicators, but it was not precluded from earning payment for the collaborative quality initiative or efficiency components of the program. CQIs are outlined later in this report.

3. Maintain high performance on five intensive care unit ventilator bundle measures described in Attachment B of the 2010 P4P program document. High performance is defined as a performance rate of 95 percent or better on each measure.

   If a hospital's performance fell below the established threshold, the hospital was requested to file an action plan with a timeline for bringing performance back up to the established threshold. If a hospital failed to either file the action plan or meet the goals of the plan within the agreed timeframe, it was not eligible for payment for the quality indicator measures of the program. However, it was not be precluded from earning payment for the CQI or efficiency measures of the program.

Quality Indicators

Hospitals were evaluated on the following six quality indicators in the 2010 Pay for Performance program:

- Heart failure
- Pneumonia
- Surgical infection prevention
- Acute myocardial infarction
- Central line associated blood stream infection rates
- Acute myocardial infarction – percutaneous coronary intervention

Most of these indicators were scored on a "perfect care" basis. This scoring methodology requires a hospital to meet the requirements for all applicable measures for each patient. If one of more of the measures was not met and the measure was not contraindicated, the hospital did not receive credit for that patient.

Efficiency Initiatives

In 2010, hospital efficiency was distributed according to two measures: a hospitals' standardized inpatient cost per case relative to the statewide mean and a hospital trend measure.

Collaborative Quality Initiatives

In 2010, hospitals were evaluated on their participation in the following six Collaborative Quality Initiatives (CQIs).

- BCBSM Cardiovascular Consortium (BMC2)
- Michigan Bariatric Surgery Collaborative (MBSC)
- Michigan Breast Oncology Quality Improvement Initiative (MiBOQI)
- Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative (MSTCVS)
- Michigan Surgical Quality Collaborative (MSQC)
- MHA Keystone: Hospital Associated Infections)

Appendix F provides a brief description of each of the CQIs included in the Hospital Pay for Performance program.

Other Quality Initiatives

Blue Distinction Centers[24, 25]

BCBSM centers of excellence in hospital care are now called Blue Distinction Centers for Specialty Care®.

Blue Cross Blue Shield of Michigan and Blue Care Network, together with the national Blue Cross and Blue Shield Association, have awarded the national Blue Distinction Centers for Specialty Care designation to Michigan hospitals that meet strict requirements for delivering quality health care in specific specialties.

The designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert physicians' and medical organizations' recommendations. Our goal is to help consumers find quality specialty care, while enabling and encouraging health care professionals to improve the overall quality and delivery of care nationwide.

The four Blue Distinction designations are:
- Blue Distinction Centers for Bariatric Surgery®
- Blue Distinction Centers for Cardiac Care®
- Blue Distinction Centers for Complex and Rare Cancers®
- Blue Distinction Centers for Transplants®

The Michigan Quality Improvement Consortium[26]

The Michigan Quality Improvement Consortium is a collaborative effort of physicians and others from Michigan health maintenance organizations, the Michigan State Medical Society, the Michigan Osteopathic Association, the Michigan Association of Health Plans, the Michigan Peer Review Organization and Blue Cross Blue Shield of Michigan.

[24]http://blueslink.bcbsm.com/bluesweek/bluesnews/2010/03.10.10/031010a.html
[25]http://www.bcbsm.com/home/where_you_can_go_for_care/centers_of_excellence.shtml
[26]http://www.bcbsm.com/home/healthier/health_care_partnerships.shtml

The consortium uses a collaborative approach to develop and implement guidelines for the treatment of common conditions as well as performance measures to show how often the guidelines are being used. The guidelines support the delivery of consistent, evidence-based health care services that will improve health outcomes for Michigan patients.

The consortium has developed evidence-based practice guidelines for the treatment of diabetes, asthma, depression, heart failure and tobacco control.

MQIC guidelines are based on scientific evidence as reported in the most current national guidelines and feedback from MQIC-participating health plans, providers, the Michigan Department of Community Health and medical specialty societies.

Michigan Health & Safety Coalition

BCBSM provided leadership, funding and staff support to the MH&SC, an independent non-profit organization. In addition to BCBSM, MH&SC members included professional and provider organizations, consumers, purchaser groups and the Michigan Department of Community Health. The MH&SC was committed to improving patient safety in all health care settings.

The MH&SC actively promoted hospital participation in The Leapfrog Group's annual survey of safety and quality and was a licensee of Leapfrog's data set which is used for safety analysis and improvement. The 2009 survey included participation from 89 Michigan hospitals.

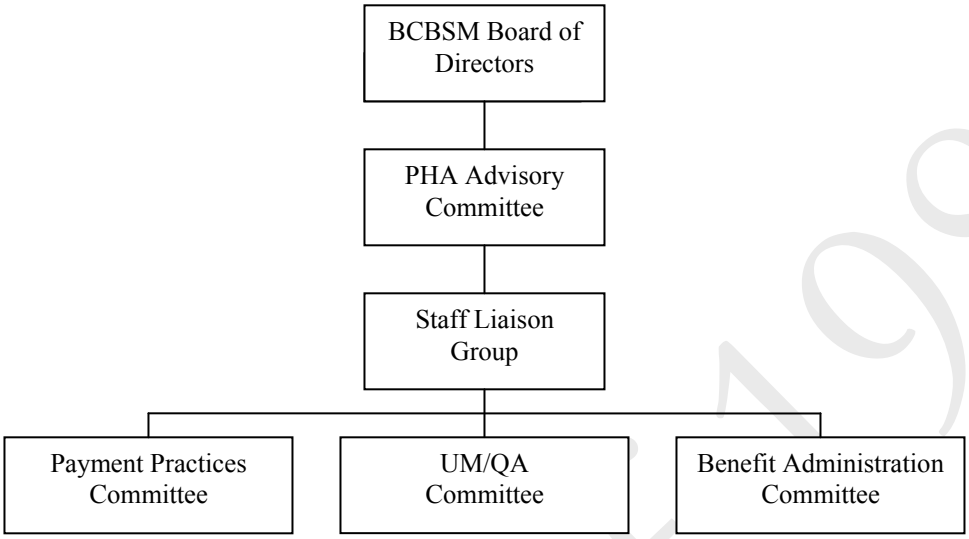
Provider Relations

During this review period, BCBSM maintained effective relations with hospitals through the contract administration process and a formal appeals process.

Contract Administration Process

The Participating Hospital Agreement provides for an ongoing contract administration process (CAP) through which participating hospitals can provide non-binding input and recommendations to BCBSM. The CAP is organized through several committees comprised of BCBSM staff or appointees, Michigan Health and Hospital Association staff or appointees, and representatives from participating hospitals. The organization of the contract administration process is as follows:

Chart 6
Contract Administration Committee Structure



The role of each PHA committee is described below. All PHA committees meet throughout the year as necessary. A list of topics discussed by each committee during the reporting period is included in Appendix G.

PHA Advisory Committee

This committee is made up of BCBSM board members and hospital CEOs. The group is charged with providing input and making non-binding recommendations to the BCBSM board of directors regarding the administration of and any modifications to the Participating Hospital Agreement.

Staff Liaison Group

The Staff Liaison Group is comprised of MHA and BCBSM executive staff and the co-chairpersons of the Benefit Administration Committee, Utilization Management and Quality Assessment Committee and Payment Practices Committee. The Staff Liaison Group meets as necessary to oversee and coordinate the activities of these three committees and to develop recommendations and reports to the PHA Advisory Committee.

Utilization Management and Quality Assessment Committee

This committee includes BCBSM senior and mid-level management, Michigan Health and Hospital Association staff and representatives from the participating hospitals. The committee provides input on matters related to utilization, quality and health management activities.

Benefit Administration Committee

The Benefit Administration Committee handles matters related to problems administering the PHA. The Committee consists of BCBSM and MHA administrative staff and personnel from participating hospitals.

CONCLUSION

Cost Goal

During the 2009-2010 reporting period, the two-year average percent change in hospital payments per 1000 members decreased less than one percent. The PA 350 cost goal was to limit the increase to 0.5 percent. The downward trend was due to an average decrease in use of almost 8 percent for inpatient admissions and 1.2 percent for outpatient visits. There were a number of factors that influenced hospital payments. The major factors are summarized below:

- Traditional membership continues to decline and, overall, hospital cost performance showed the trend in hospital payments per 1000 members remaining relatively flat. The hospital payment per 1000 members decreased approximately $47,016 or 0.3 percent from 2009 to 2010, while membership decreased approximately 30,000 members or 19.7 percent.
- Circulatory, musculoskeletal, digestive and respiratory conditions experienced a three-year payout that accounted for 55 percent of total inpatient payments. Many of the top 50 diagnoses included angina, heart attacks, irregular heart rhythms, osteoarthritis, spinal stenosis, diverticulitis, appendicitis, acute respiratory failure and pneumonia.
- Surgery, laboratory/pathology and diagnostic X-ray accounted for 67 percent of the total three-year outpatient payout. These top three types of service are used in conjunction with one another to provide patient care. Review of the major diagnostic categories showed that the Traditional hospital membership tends to be older with cardiac and musculoskeletal issues which would require the use of surgery, laboratory/pathology and diagnostic X-ray types of service.
- The majority of hospital payments were for members in the age category 55 years and older, a population for which the demand for hospital care and health resources will rise as they continue to age.

Access Goal

BCBSM met the access goal for the hospital provider class. BCBSM offered licensed providers the opportunity to participate by signing a formal participation agreement. One hundred percent participation was achieved in both years of the reporting period. On a regional level, there were a sufficient number of hospitals located in each region. Effective provider communications, BCBSM's reimbursement methodology, financial incentives for quality and safety community programs and provider satisfaction studies all helped achieve the access goal.

Quality of Care Goal

BCBSM achieved the quality of care goal. Hospitals were required to meet qualification standards to ensure they were capable of providing high quality care to BCBSM members. Quality controls, which included utilization review initiatives and audits, ensured that services rendered were medically necessary, appropriate for the patient's condition and in accordance with the PHA. Quality management initiatives such as the PHA Pay for Performance Program, Blue Distinction Centers and the Michigan Quality Improvement Consortium promoted patient safety and the delivery of high quality care. The PHA contract administration process gave providers a formal process to address concerns and provide input and recommendations on issues related to doing business with BCBSM.

APPENDIX A

Overview of Public Act 350

This section briefly describes the provider class plan annual reporting requirements mandated under Public Act 350.

Annual reporting requirements

The provider class plan annual reports are submitted pursuant to section 517 of PA 350, which requires BCBSM to submit to the Commissioner an annual report for each provider class that shows the level of BCBSM's achievement of the goals provided in section 504.

PA 350 Goals

The term "goals", used in section 517 above, refers to specific cost, access and quality goals described in section 504. This section states:

"A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of health care services in accordance with the following goals:

Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." This is expressed by the following formula:

$$\left[\frac{((100 + I) \times (100 + REG))}{100} \right] - 100$$

Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

Quality of Health Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

Cost Goal Calculation

P.A. 350 Cost Goal Formula

The P.A. 350 cost goal formula , as stated in the Act is:

$$\frac{((100 + I) \times (100 + REG)}{100} \quad -100$$

Goal Calculations

Year of Determination	2011
I (CY 2009 - 2010)	0.853%
REG (CY 2007 - 2010)	-0.384%

Applying these indices into the formula, the cost goal becomes:

$$\frac{((100 + I\%) \times (100 + REG\%)}{100} \quad -100 = \mathbf{0.469\%}$$

PA 350 Cost Goal Assumptions

Year	Population (1)	Real GNP (2)	Per Capita GNP	Implicit GNP Price Deflator (3)	Percent Change PC GNP	Percent Change IPD
2006	298,217,000	$ 13,129,500,000,000	$ 44,026.67	104.22		
2007	300,913,000	$ 13,563,300,000,000	$ 45,073.83	107.07	**2.378%**	**2.735%**
2008	303,598,000	$ 13,240,500,000,000	$ 43,611.95	109.17	**-3.243%**	**1.961%**
2009	305,529,000	$ 13,246,000,000,000	$ 43,354.31	109.92	**-0.591%**	**0.687%**
2010	310,463,939	$ 13,449,300,000,000	$ 43,320.01	111.04	**-0.079%**	**1.019%**

(1) Population projections based on 2000 census released May 11, 2004
www.census.gov/ipc/www/usinterimproj/usproj detail file RTT (Total Resident Population)

(2) http://research.stlouisfed.org/fred2/series/GNPC96/downloaddata?cid=106

(3) http://research.stlouisfed.org/fred2/series/GNPDEF/downloaddata?cid=21

Definitions

Section 504 of the Act also provides the following definitions for terms used in the cost goal calculation:

"'Gross Domestic Product (GDP) in constant dollars' means that term as defined and annually published by the United States Department of Commerce, Bureau of Economic Analysis."

"'Implicit price deflator for gross national product' means that term as defined and annually published by the United States Department of Commerce, Bureau of Economic Analysis."

"'Inflation' (I) means the arithmetic average of the percentage changes in the implicit price deflator for gross national product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made."

"'Compound rate of inflation and real economic growth' means the ratio of the quantity 100 plus inflation multiplied by the quantity 100 plus real economic growth to 100; minus 100."

"'Rate of change in the total corporation payment per member to each provider class' means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the Commissioner's determination."

"'Real economic growth' (REG) means the arithmetic average of the percentage changes in the per capita gross national product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made."

Determination Process

Under PA 350, the commissioner is required to consider information presented in the annual report, as well as all other relevant factors that might affect the performance of a particular provider class, in making a determination with respect to that class.

Section 509 of the Act outlines factors that should be considered by the commissioner to "determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan." Many of these factors are beyond BCBSM's direct control and may adversely impact the cost and use of health care services for a particular provider class. Specifically, section 509(4) states:

The commissioner shall consider all of the following in making a determination...:

(a) Annual reports transmitted pursuant to section 517.

(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. The commissioner shall give weight to each of the goals provided in section 504, shall not focus on one goal independently of the other goals of the corporation, and shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers.

(c) Information submitted or obtained for the record concerning:

- *Demographic trends;*
- *Epidemiological trends;*
- *Long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d);*
- *Sudden changes in circumstances;*
- *Administrative agency or judicial actions;*
- *Changes in health care practices and technology; and,*
- *Changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.*

(d) Health care legislation of this state or of the federal government. As used in this subdivision, 'health care legislation' does not include Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.

(e) Comments received from an individual provider of the appropriate provider group, or from an organization or association that represents the appropriate provider class, and comments received pursuant to section 505(2).

After considering the information and factors described in section 509(4), the goals of a health care corporation as provided in sections 504, and the objectives contained in the provider class plan, the commissioner shall determine one of the following [as stated under section 510(1)]:

(a) That the provider class plan achieves the goals of the corporation as provided in section 504.

(b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to factors listed in section 509(4).

(c) That a provider class plan does not substantially achieve one or more of the goals of the corporation as provided in section 504.

A determination made by the commissioner under section 510 1(a) or 1(b) would require no further action by the corporation. Upon a 511(1)(c) determination by the commissioner, under section 511, the corporation:

(1) Within 6 months or a period determined by the commissioner..., shall transmit to the commissioner a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the

commissioner pursuant to section 510(2). In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.

If after 6 months or a period determined by the commissioner..., the health care corporation has failed to act pursuant to subsection (1), the commissioner shall prepare a provider class plan..., for that provider class.

The findings of the commissioner may be disputed by any party through an appeals process available under section 515 of PA 350.

APPENDIX B

Technical Notes

The data indices presented in the 2008, 2009, and 2010 databases and analyzed in the annual reports reflect a defined subset of BCBSM claims experience. The data specifications and collection methodologies are discussed in the following sections.

Data Elements and Collection

The basic statistics analyzed for each provider class are total payments and utilization, from which an average price per utilization unit is derived. These data were collected from BCBSM data files that are based on claims submitted to the Corporation and approved for payment to the provider or in some cases, the subscriber.

The data collection period captures health care services incurred during specific twelve-month calendar years and paid through fourteen months. For example, the 2010 dataset includes all services incurred between 1/1/10 and 12/31/10, and paid from 1/1/10 through 2/28/11. It is reasonable to expect that for the hospital provider class, approximately 97 percent of total experience is captured.

Participation rates are based on providers who sign a BCBSM participation agreement and the total number of licensed providers registered with BCBSM.

Scope of the Data

Provider Class Accountability

PA 350 requires BCBSM to report its Traditional line of business for the purposes of provider class accountability. However, for the ancillary provider classes, including pharmacy, managed care experience is included. BCBSM membership systems capture members' product line information only once, reflecting the member's hospital/medical-surgical coverage (e.g., a member with managed care pharmacy coverage but traditional hospital/medical-surgical coverage is considered a traditional member).

Underwritten groups and administrative services contracts are included. For ancillary provider classes, complementary claims and membership data is included. The data excludes the Federal Employee Program and non-Michigan liability such as claims paid through the Inter-Plan Teleprocessing System for out-of-state Blue members. Claims incurred out-of-state by BCBSM members are also excluded.

Blue Care Network data are excluded from the reporting requirements referred to in PA 350 Section 502(a) (11) and the HMO Act.

Regional Experience

Regions selected for analysis are compatible with Michigan Metropolitan Statistical Areas (MSAs) and provide an acceptable basis for analysis of access as well as of provider practice patterns.

The data cover total Traditional business, divided into nine regions. Regions one through nine represent groups of Michigan counties. Michigan claims experience with unidentified zip codes was allocated among the nine regions according to the distribution of data with identifiable zip codes.

Membership

This report includes all BCBSM Traditional members residing in Michigan.

The regions used for analysis pertain to the location where services were delivered. For example, region one experience represents payments to region one providers for services rendered to BCBSM members regardless of residency. This is because subscribers who live in one region may receive services in another region because they reside near a border or want services from a provider in another region.

APPENDIX C

Supporting Tables and Charts

Appendix #	Description
A1	2008-2010 Cost, Use and Price Experience by MDC Inpatient
A2	2008-2010 Cost, Use, and Price Experience by Top 50 Diagnostic Related Groups
A3	2008-2010 Outpatient Cost, Use and Price Experience by MDC Outpatient
A4	2008-2010 Cost, Use and Price Experience by Top 50 Diagnoses Outpatient
A5	2008-2010 Cost, Use and Price Experience by Top 50 Diagnoses Inpatient
A6	2007 Outpatient Traditional Payments by Age

Appendix – A1
Hospital Provider Class – Inpatient
2010 Cost, Use, and Price Experience by MDC

Inpatient Hospital by Major Diagnostic Catergory	Two year average rate of change Per 1000 Members				2010 Payments	2010 Days/Svcs	2010 Adm	2010 Avg Pmt/Day	2010 Avg Pmt/Adm	Pct to Total Payout
	Payments	Days	Adm	Pmt/Adm						
Nervous System	-18.8%	-19.2%	-16.7%	-2.5%	$ 10,014,657	2,646	543	$ 3,785	$ 18,443	5.7%
Disease of the Eye	-15.0%	-11.0%	24.6%	-31.8%	$ 94,900	35	17	$ 2,711	$ 5,582	0.1%
Disease of ENT	32.6%	4.1%	28.7%	3.0%	$ 1,476,561	392	154	$ 3,767	$ 9,588	0.8%
Respiratory System	-3.5%	-15.9%	-11.9%	9.5%	$ 14,103,810	4,491	1,016	$ 3,140	$ 13,882	8.0%
Circulatory System	-10.2%	-16.5%	-16.7%	7.9%	$ 27,342,218	4,874	1,224	$ 5,610	$ 22,338	15.5%
Digestive System	-2.7%	-8.3%	-8.6%	6.5%	$ 17,258,026	6,107	1,299	$ 2,826	$ 13,286	9.8%
Hepatobiliary Sys/Pancreas	-30.7%	-26.7%	-23.8%	-9.1%	$ 5,687,811	1,902	378	$ 2,990	$ 15,047	3.2%
Musculorskeletal	6.2%	-3.2%	-3.7%	10.3%	$ 38,503,669	6,214	1,834	$ 6,196	$ 20,994	21.9%
Skin & Subcutaneous Disease	10.3%	22.8%	15.3%	-4.3%	$ 3,196,290	1,491	374	$ 2,144	$ 8,546	1.8%
Nutritional Disease	-10.7%	-16.2%	-14.3%	4.2%	$ 6,507,689	1,548	523	$ 4,204	$ 12,443	3.7%
Kidney/Urinary Tract	0.1%	-12.6%	-6.2%	6.7%	$ 5,107,616	1,470	426	$ 3,475	$ 11,990	2.9%
Male Reproductive Sys	17.8%	20.4%	8.2%	8.9%	$ 1,602,537	286	132	$ 5,603	$ 12,140	0.9%
Female Reproductive Sys	-13.8%	-21.4%	-22.2%	10.8%	$ 5,021,206	1,100	487	$ 4,565	$ 10,310	2.8%
Pregnancy	-9.3%	-19.2%	-17.9%	10.4%	$ 6,187,494	3,267	1,302	$ 1,894	$ 4,752	3.5%
Newborns in Perinatal Period	-22.6%	-64.8%	-14.8%	-9.2%	$ 4,257,953	1,049	1,216	$ 4,059	$ 3,502	2.4%
Disease of the Blood	-1.2%	-18.6%	-10.9%	10.8%	$ 1,938,927	627	156	$ 3,092	$ 12,429	1.1%
Neoplasms	3.9%	-8.6%	14.2%	-9.0%	$ 4,544,539	1,156	132	$ 3,931	$ 34,428	2.6%
Infectious Disease	-10.5%	-18.9%	-3.6%	-7.1%	$ 7,394,409	2,142	321	$ 3,452	$ 23,036	4.2%
Mental Disorders	-20.4%	-27.4%	-29.2%	12.5%	$ 3,350,739	3,327	505	$ 1,007	$ 6,635	1.9%
Alcohol/Drug Abuse	-14.8%	-6.8%	-14.4%	-0.5%	$ 301,718	184	44	$ 1,640	$ 6,857	0.2%
Injury Poisoning	-10.3%	-18.4%	-21.4%	14.2%	$ 4,351,656	1,403	316	$ 3,102	$ 13,771	2.5%
Burns	12.8%	-20.4%	6.8%	5.7%	$ 126,865	23	6	$ 5,516	$ 21,144	0.1%
Factors Influencing Health Status	-10.3%	-20.1%	-18.7%	10.3%	$ 6,726,733	2,963	446	$ 2,270	$ 15,082	3.8%
Human Immunodeficiency Virus Infections	207.0%	218.3%	55.7%	97.1%	$ 139,467	46	5	$ 3,032	$ 27,893	0.1%
Other										
Total	**-6.2%**	**-17.2%**	**-12.7%**	**7.4%**	**$ 176,189,256**	**48,994**	**12,916**	**$ 3,596**	**$ 13,641**	**100%**

Appendix – A1
Hospital Provider Class – Inpatient
2009 Cost, Use, and Price Experience by MDC

Inpatient Hospital by Major Diagnostic Catergory	Two year average rate of change Per 1000 Members				2009 Payments	2009 Days/Svcs	2009 Adm	2009 Avg Pmt/Day	2009 Avg Pmt/Adm	Pct to Total Payout
	Payments	Days	Adm	Pmt/Adm						
Nervous System	21.0%	16.0%	1.5%	19.2%	$ 15,366,567	4,078	812	$ 3,768	$ 18,924	6.6%
Disease of the Eye	18.4%	8.1%	-10.0%	31.6%	$ 139,106	49	17	$ 2,839	$ 8,183	0.1%
Disease of ENT	-20.2%	-23.9%	-25.9%	7.7%	$ 1,386,982	469	149	$ 2,957	$ 9,309	0.6%
Respiratory System	0.3%	-9.9%	-5.6%	6.3%	$ 18,208,819	6,656	1,436	$ 2,736	$ 12,680	7.8%
Circulatory System	5.3%	-6.2%	-1.6%	7.0%	$ 37,917,791	7,274	1,831	$ 5,213	$ 20,709	16.2%
Digestive System	20.8%	3.1%	7.5%	12.4%	$ 22,091,562	8,298	1,771	$ 2,662	$ 12,474	9.4%
Hepatobiliary Sys/Pancreas	30.2%	5.6%	9.4%	19.0%	$ 10,231,296	3,232	618	$ 3,166	$ 16,555	4.4%
Musculorskeletal	17.3%	-2.6%	0.3%	16.9%	$ 45,164,590	7,998	2,373	$ 5,647	$ 19,033	19.3%
Skin & Subcutaneous Disease	22.8%	-8.1%	-5.8%	30.3%	$ 3,609,455	1,513	404	$ 2,386	$ 8,934	1.5%
Nutritional Disease	6.6%	-6.2%	1.6%	4.9%	$ 9,078,408	2,302	760	$ 3,944	$ 11,945	3.9%
Kidney/Urinary Tract	14.2%	-1.9%	2.4%	11.4%	$ 6,357,172	2,096	566	$ 3,033	$ 11,232	2.7%
Male Reproductive Sys	9.1%	-15.3%	-9.1%	20.0%	$ 1,693,955	296	152	$ 5,723	$ 11,144	0.7%
Female Reproductive Sys	13.2%	-6.5%	-3.3%	17.0%	$ 7,259,632	1,744	780	$ 4,163	$ 9,307	3.1%
Pregnancy	-9.8%	-9.4%	-9.4%	-0.4%	$ 8,498,751	5,034	1,975	$ 1,688	$ 4,303	3.6%
Newborns in Perinatal Period	6.2%	-19.2%	-11.7%	20.3%	$ 6,849,310	3,715	1,777	$ 1,844	$ 3,854	2.9%
Disease of the Blood	1.9%	-19.2%	-5.0%	7.3%	$ 2,445,796	959	218	$ 2,550	$ 11,219	1.0%
Neoplasms	-17.9%	-22.9%	-28.4%	14.7%	$ 5,448,384	1,576	144	$ 3,457	$ 37,836	2.3%
Infectious Disease	21.8%	12.7%	9.3%	11.4%	$ 10,286,762	3,292	415	$ 3,125	$ 24,787	4.4%
Mental Disorders	-15.4%	-14.1%	-14.7%	-0.9%	$ 5,241,683	5,712	889	$ 918	$ 5,896	2.2%
Alcohol/Drug Abuse	-11.6%	-22.5%	-9.6%	-2.2%	$ 441,104	246	64	$ 1,793	$ 6,892	0.2%
Injury Poisoning	8.4%	-9.3%	8.3%	0.1%	$ 6,041,541	2,143	501	$ 2,819	$ 12,059	2.6%
Burns	-50.0%	-58.1%	-43.0%	-12.3%	$ 140,048	36	7	$ 3,890	$ 20,007	0.1%
Factors Influencing Health Status	14.8%	-3.2%	2.4%	12.1%	$ 9,337,340	4,622	683	$ 2,020	$ 13,671	4.0%
Human Immunodeficiency Virus Infections	-93.0%	-83.0%	-39.5%	-88.4%	$ 56,594	18	4	$ 3,144	$ 14,148	0.0%
Other	2999.0%	2979.6%	38.2%	2142.5%	$ 632,467	349	77	$ 1,812	$ 8,214	0.3%
Total	**9.7%**	**-5.1%**	**-3.0%**	**13.2%**	**$ 233,925,115**	**73,707**	**18,423**	**$ 3,174**	**$ 12,697**	**100%**

Appendix – A1

Hospital Provider Class – Inpatient

2008 Cost, Use, and Price Experience by MDC

Inpatient Hospital by Major Diagnostic Catergory	2008 Payments	2008 Days	2008 Adm	2008 Avg Pmt/Day	2008 Avg Pmt/Adm	Pct to Total Payout
Nervous System	$ 13,445,523	3,721	847	$ 3,613	$ 15,874	6.0%
Disease of the Eye	$ 124,397	48	20	$ 2,592	$ 6,220	0.1%
Disease of ENT	$ 1,840,422	653	213	$ 2,818	$ 8,640	0.8%
Respiratory System	$ 19,222,112	7,821	1,611	$ 2,458	$ 11,932	8.5%
Circulatory System	$ 38,142,210	8,213	1,971	$ 4,644	$ 19,352	16.9%
Digestive System	$ 19,370,890	8,520	1,745	$ 2,274	$ 11,101	8.6%
Hepatobiliary Sys/Pancreas	$ 8,318,402	3,242	598	$ 2,566	$ 13,910	3.7%
Musculorskeletal	$ 40,772,341	8,695	2,505	$ 4,689	$ 16,276	18.1%
Skin & Subcutaneous Disease	$ 3,113,121	1,744	454	$ 1,785	$ 6,857	1.4%
Nutritional Disease	$ 9,019,920	2,598	792	$ 3,472	$ 11,389	4.0%
Kidney/Urinary Tract	$ 5,896,832	2,262	585	$ 2,607	$ 10,080	2.6%
Male Reproductive Sys	$ 1,644,416	370	177	$ 4,444	$ 9,290	0.7%
Female Reproductive Sys	$ 6,793,512	1,976	854	$ 3,438	$ 7,955	3.0%
Pregnancy	$ 9,972,824	5,884	2,308	$ 1,695	$ 4,321	4.4%
Newborns in Perinatal Period	$ 6,826,077	4,871	2,130	$ 1,401	$ 3,205	3.0%
Disease of the Blood	$ 2,541,783	1,257	243	$ 2,022	$ 10,460	1.1%
Neoplasms	$ 7,024,085	2,165	213	$ 3,244	$ 32,977	3.1%
Infectious Disease	$ 8,942,278	3,093	402	$ 2,891	$ 22,244	4.0%
Mental Disorders	$ 6,559,222	7,038	1,103	$ 932	$ 5,947	2.9%
Alcohol/Drug Abuse	$ 528,545	336	75	$ 1,573	$ 7,047	0.2%
Injury Poisoning	$ 5,901,514	2,502	490	$ 2,359	$ 12,044	2.6%
Burns	$ 296,712	91	13	$ 3,261	$ 22,824	0.1%
Factors Influencing Health Status	$ 8,611,280	5,054	706	$ 1,704	$ 12,197	3.8%
Human Immunodeficiency Virus Infections	$ 852,657	112	7	$ 7,613	$ 121,808	0.4%
Other	$ 21,610	12	59	$ 1,801	$ 366	0.0%
Total	**$ 225,782,685**	**82,278**	**20,121**	**$ 2,744**	**$ 11,221**	**100%**

Appendix – A2

Hospital Provider Class – Inpatient

2010 Cost, Use, and Price Experience by Top 50 Diagnostic Related Groups

Diagnositc Related Group	Two year average rate of change Per 1000 Members: Payments	Days	Admissions	Pmt/Adm	2010 Payments	2010 Days	2010 Adm	2010 Avg Pmt/Day	2010 Avg Pmt/Case	Pct to Total Payout
Non-Extensive Burns W/O O.R. Procedure	59.9%	33.2%	41.9%	12.7%	$ 5,459,070	588	172	$ 9,284	$ 31,739	3.1%
Tissue	11.8%	1.9%	12.4%	-0.6%	$ 3,468,197	333	166	$ 10,415	$ 20,893	2.0%
Craniotomy Age 0-17	7.6%	12.9%	5.9%	1.6%	$ 3,276,116	612	17	$ 5,353	$192,713	1.9%
Ventilation 96+ Hrs With Mcc	50.7%	22.9%	43.5%	5.0%	$ 2,078,724	604	91	$ 3,442	$ 22,843	1.2%
Without Cc/Mcc	9.1%	16.2%	7.2%	1.8%	$ 1,863,603	967	290	$ 1,927	$ 6,426	1.1%
Rehabilitation W Cc/Mcc	10.7%	12.3%	8.8%	1.8%	$ 1,677,157	311	124	$ 5,393	$ 13,525	1.0%
Vaginal Delivery W/O Complicating Diagnoses	35.7%	37.2%	44.7%	-6.2%	$ 1,513,253	305	36	$ 4,961	$ 42,035	0.9%
Urethral Stricture Age 0-17	9.4%	7.2%	6.6%	2.6%	$ 1,379,698	160	89	$ 8,623	$ 15,502	0.8%
O.R. Procedures For Obesity Without Cc/Mcc	-9.6%	-11.9%	-0.3%	-9.3%	$ 1,357,786	475	36	$ 2,858	$ 37,716	0.8%
Splenectomy Age >17	-7.2%	-3.9%	-11.0%	4.3%	$ 1,863,603	967	290	$ 1,927	$ 6,426	1.1%
Top 10	**25.3%**	**2.7%**	**8.3%**	**15.7%**	**$ 90,522,730**	**22,663**	**6,288**	**$ 3,994**	**$ 14,396**	**51.4%**
Top 50	26.0%	18.3%	17.6%	7.2%	$ 23,358,222	4,635	1,042	$ 5,040	$ 22,417	13.3%
Grand Total	**-6.2%**	**-17.2%**	**-12.7%**	**7.4%**	**$ 176,189,256**	**48,994**	**12,916**	**$ 3,596**	**$ 13,641**	**100.0%**

Appendix – A2

Hospital Provider Class – Inpatient

2009 Cost, Use, and Price Experience by Top 50 Diagnostics Related Groups

Diagnositc Related Group	Two year average rate of change Per 1000 Members				2009 Payments	2009 Days	2009 Adm	2009 Avg Pmt/Day	2009 Avg Pmt/Case	Pct to Total Payout
	Payments	Days	Admissions	Pmt/Adm						
Non-Extensive Burns W/O O.R. Procedure	-8.3%	-21.5%	-20.5%	15.3%	$ 4,251,768	550	151	$ 7,730	$ 28,157	1.8%
Signs & Symptoms Of Musculoskeletal Systen	0.4%	-7.5%	-15.7%	19.1%	$ 3,865,942	407	184	$ 9,499	$ 21,011	1.7%
Craniotomy Age 0-17	-22.3%	-32.7%	-29.4%	10.1%	$ 3,793,845	675	20	$ 5,621	$189,692	1.6%
Septicemia Or Severe Sepsis Without Mechani	13.7%	5.4%	-1.6%	15.6%	$ 1,718,797	612	79	$ 2,808	$ 21,757	0.7%
Uterine And Adnexa Procedure For Non-Malig	24.3%	10.5%	5.9%	17.4%	$ 2,128,128	1,037	337	$ 2,052	$ 6,315	0.9%
Rehabilitation W Cc/Mcc	-13.1%	-36.2%	-24.4%	15.0%	$ 1,886,605	345	142	$ 5,468	$ 13,286	0.8%
Vaginal Delivery W/O Complicating Diagnose	-6.3%	-14.5%	-21.8%	19.9%	$ 1,389,187	277	31	$ 5,015	$ 44,812	0.6%
Urethral Stricture Age 0-17	8.6%	4.8%	-11.9%	23.2%	$ 1,571,673	186	104	$ 8,450	$ 15,112	0.7%
O.R. Procedures For Obesity Without Cc/Mcc	-2.7%	-24.1%	-26.7%	32.7%	$ 1,870,941	672	45	$ 2,784	$ 41,576	0.8%
Splenectomy Age >17	46.2%	33.6%	27.6%	14.6%	$ 2,502,469	1,254	406	$ 1,996	$ 6,164	1.1%
Top 10	**-3.1%**	**-5.6%**	**-9.4%**	**6.9%**	**$ 89,989,707**	**27,480**	**7,234**	**$ 3,275**	**$ 12,440**	**38.5%**
Top 50	-4.9%	-14.6%	-12.1%	8.2%	$ 23,091,753	4,880	1,104	$ 4,732	$ 20,916	9.9%
Grand Total	**9.7%**	**-5.5%**	**-3.0%**	**13.2%**	**$ 233,925,115**	**73,707**	**18,423**	**$ 3,174**	**$ 12,697**	**100.0%**

Appendix – A2

Hospital Provider Class – Inpatient

2008 Cost, Use, and Price Experience by Top 50 Diagnostics Related Groups

Diagnositc Related Group	Payments	2008 Days	2008 Adm	2008 Avg Pmt/Day	2008 Avg Pmt/Case	Pct to Total Payout
Non-Extensive Burns W/O O.R. Procedure	$ 4,908,565	742	201	$ 6,615	$ 24,421	2.2%
Signs & Symptoms Of Musculoskeletal Systen	$ 4,076,559	466	231	$ 8,748	$ 17,647	1.8%
Craniotomy Age 0-17	$ 5,169,038	1,062	30	$ 4,867	$172,301	2.3%
Septicemia Or Severe Sepsis Without Mechani	$ 1,600,341	615	85	$ 2,602	$ 18,828	0.7%
Uterine And Adnexa Procedure For Non-Malig	$ 1,812,636	994	337	$ 1,824	$ 5,379	0.8%
Rehabilitation W Cc/Mcc	$ 2,298,368	573	199	$ 4,011	$ 11,550	1.0%
Vaginal Delivery W/O Complicating Diagnose	$ 1,570,380	343	42	$ 4,578	$ 37,390	0.7%
Urethral Stricture Age 0-17	$ 1,532,951	188	125	$ 8,154	$ 12,264	0.7%
O.R. Procedures For Obesity Without Cc/Mcc	$ 2,036,900	938	65	$ 2,172	$ 31,337	0.9%
Splenectomy Age >17	$ 1,812,636	994	337	$ 1,824	$ 5,379	0.8%
Top 10	**$ 98,374,791**	**30,825**	**8,452**	**$ 3,191**	**$ 11,639**	**43.6%**
Top 50	$ 25,714,804	6,052	1,330	$ 4,249	$ 19,334	11.4%
Grand Total	**$ 225,782,685**	**82,548**	**20,121**	**$ 2,735**	**$ 11,221**	**100.0%**

Appendix – A3

Hospital Provider Class – Outpatient

2010 Cost, Use, and Price Experience by MDC

Outpatient Hospital by Major Diagnostic Category	Two year average rate of change Per 1000 Members			2010 Payments	2010 Visits	Avg Pmt/Vst	Pct of Total	
	Payments	Visits	Pmt/Vst				Payout	Visits
Nervous System	-2.1%	7.1%	-8.6%	$ 5,700,400	112,017	$50.89	3.9%	3.1%
Disease of the Eye	-3.9%	-0.4%	-3.5%	$ 2,194,312	30,606	$71.70	1.5%	0.9%
Disease of ENT	-4.9%	-2.8%	-2.2%	$ 5,158,383	120,006	$42.98	3.5%	3.4%
Respiratory System	0.6%	-8.0%	9.3%	$ 10,555,237	246,485	$42.82	7.1%	6.9%
Circulatory System	12.4%	12.1%	0.2%	$ 14,819,923	271,902	$54.50	10.0%	7.6%
Digestive System	5.3%	-2.8%	8.4%	$ 15,141,716	469,494	$32.25	10.2%	13.1%
Hepatobiliary Sys/Pancreas	0.2%	-6.4%	7.1%	$ 3,419,636	87,746	$38.97	2.3%	2.5%
Musculorskeletal	-0.7%	3.6%	-4.2%	$ 25,864,627	514,842	$50.24	17.5%	14.4%
Skin & Subcutaneous Disease	-0.2%	8.1%	-7.7%	$ 10,564,336	222,275	$47.53	7.1%	6.2%
Nutritional Disease	-2.4%	2.0%	-4.3%	$ 4,457,302	260,699	$17.10	3.0%	7.3%
Kidney/Urinary Tract	-4.8%	-5.8%	1.1%	$ 6,858,819	213,535	$32.12	4.6%	6.0%
Male Reproductive Sys	10.1%	8.5%	1.5%	$ 2,754,247	41,423	$66.49	1.9%	1.2%
Female Reproductive Sys	-5.6%	-5.0%	-0.7%	$ 4,527,812	119,896	$37.76	3.1%	3.4%
Pregnancy	-14.2%	-13.6%	-0.8%	$ 930,061	23,613	$39.39	0.6%	0.7%
Newborns in Perinatal Period	-33.5%	8.0%	-38.4%	$ 32,617	976	$33.42	0.0%	0.0%
Disease of the Blood	-19.2%	-6.7%	-13.4%	$ 2,675,840	121,683	$21.99	1.8%	3.4%
Neoplasms	34.8%	8.0%	24.9%	$ 7,086,427	113,627	$62.37	4.8%	3.2%
Infectious Disease	-20.6%	17.1%	-32.2%	$ 516,928	31,191	$16.57	0.3%	0.9%
Mental Disorders	-3.4%	-8.0%	5.1%	$ 588,637	15,588	$37.76	0.4%	0.4%
Alcohol/Drug Abuse	-13.2%	-8.6%	-5.1%	$ 173,316	6,019	$28.79	0.1%	0.2%
Injury Poisoning	-6.9%	-4.4%	-2.6%	$ 1,021,996	22,308	$45.81	0.7%	0.6%
Burns	-16.0%	-9.3%	-7.4%	$ 54,610	780	$70.01	0.0%	0.0%
Factors Influencing Health Status	20.1%	17.0%	2.6%	$ 20,738,742	508,841	$40.76	14.0%	14.2%
Human Immunodeficiency Virus	-0.2%	2.9%	-3.0%	$ 44,503	1,608	$27.68	0.0%	0.0%
Other	11.3%	-1.9%	13.5%	$ 104,808	2,263	$46.31	0.1%	0.1%
Unknown	29.9%	20.4%	7.8%	$ 2,073,184	14,341	$144.56	1.4%	0.4%
Total	**4.2%**	**2.6%**	**1.6%**	**$ 148,058,419**	**3,573,764**	**$41.43**	**100.0%**	**100.0%**

Appendix – A3

Hospital Provider Class – Outpatient

2009 Cost, Use, and Price Experience by MDC

Outpatient Hospital by Major Diagnostic Category	Two year average rate of change Per 1000 Members			2009 Payments	2009 Visits	Avg Pmt/Vst	Pct of Total	
	Payments	Visits	Pmt/Vst				Payout	Visits
Nervous System	-2.0%	21.4%	-19.3%	$ 7,250,099	130,276	$55.65	4.1%	3.0%
Disease of the Eye	-16.0%	11.9%	-25.0%	$ 2,844,317	38,271	$74.32	1.6%	0.9%
Disease of ENT	-17.6%	-3.7%	-14.4%	$ 6,760,273	153,819	$43.95	3.8%	3.5%
Respiratory System	-9.3%	6.5%	-14.8%	$ 13,070,603	333,569	$39.18	7.4%	7.7%
Circulatory System	2.0%	15.8%	-11.9%	$ 16,427,253	302,057	$54.38	9.3%	7.0%
Digestive System	-15.7%	4.2%	-19.2%	$ 17,909,497	601,970	$29.75	10.1%	13.9%
Hepatobiliary Sys/Pancreas	-5.8%	15.8%	-18.7%	$ 4,249,516	116,746	$36.40	2.4%	2.7%
Musculorskeletal	-7.9%	11.5%	-17.4%	$ 32,441,783	618,940	$52.42	18.3%	14.3%
Skin & Subcutaneous Disease	-5.9%	3.9%	-9.4%	$ 13,184,710	256,091	$51.48	7.5%	5.9%
Nutritional Disease	-28.4%	3.7%	-31.0%	$ 5,689,321	318,286	$17.87	3.2%	7.3%
Kidney/Urinary Tract	-10.7%	8.8%	-18.0%	$ 8,977,124	282,481	$31.78	5.1%	6.5%
Male Reproductive Sys	-13.0%	12.5%	-22.7%	$ 3,114,893	47,552	$65.50	1.8%	1.1%
Female Reproductive Sys	-19.1%	1.7%	-20.5%	$ 5,976,118	157,206	$38.01	3.4%	3.6%
Pregnancy	-11.7%	-6.7%	-5.4%	$ 1,350,854	34,037	$39.69	0.8%	0.8%
Newborns in Perinatal Period	-4.8%	5.8%	-10.0%	$ 61,072	1,126	$54.24	0.0%	0.0%
Disease of the Blood	8.3%	19.9%	-9.7%	$ 4,126,378	162,452	$25.40	2.3%	3.7%
Neoplasms	-7.1%	5.2%	-11.6%	$ 6,547,816	131,095	$49.95	3.7%	3.0%
Infectious Disease	-2.0%	-1.6%	-0.4%	$ 811,268	33,173	$24.46	0.5%	0.8%
Mental Disorders	-5.9%	1.9%	-7.7%	$ 758,806	21,114	$35.94	0.4%	0.5%
Alcohol/Drug Abuse	-11.5%	-14.5%	3.5%	$ 248,714	8,201	$30.33	0.1%	0.2%
Injury Poisoning	-11.0%	16.4%	-23.5%	$ 1,367,407	29,081	$47.02	0.8%	0.7%
Burns	-29.3%	-18.1%	-13.6%	$ 80,985	1,071	$75.62	0.0%	0.0%
Factors Influencing Health Status	-2.3%	18.8%	-17.7%	$ 21,517,184	541,805	$39.71	12.2%	12.5%
Human Immunodeficiency Virus	-41.7%	-9.3%	-35.7%	$ 55,520	1,946	$28.53	0.0%	0.0%
Other	-25.8%	-24.1%	-2.2%	$ 117,283	2,873	$40.82	0.1%	0.1%
Unknown	24.1%	54.1%	-19.4%	$ 1,988,836	14,835	$134.06	1.1%	0.3%
Total	**-8.5%**	**9.1%**	**-16.1%**	**$ 176,927,632**	**4,340,073**	**$40.77**	**100.0%**	**100.0%**

Appendix – A3

Hospital Provider Class – Outpatient

2008 Cost, Use, and Price Experience by MDC

Outpatient Hospital by Major Diagnostic Category	2008 Payments	2008 Visits	Avg Pmt/Vst	Pct of Total Payout	Pct of Total Visits
Nervous System	$ 7,836,997	113,665	$68.95	3.8%	2.7%
Disease of the Eye	$ 3,586,493	36,200	$99.07	1.8%	0.9%
Disease of ENT	$ 8,686,561	169,148	$51.35	4.2%	4.0%
Respiratory System	$ 15,253,589	331,709	$45.98	7.5%	7.9%
Circulatory System	$ 17,047,949	276,088	$61.75	8.3%	6.6%
Digestive System	$ 22,506,477	611,473	$36.81	11.0%	14.5%
Hepatobiliary Sys/Pancreas	$ 4,777,098	106,725	$44.76	2.3%	2.5%
Musculorskeletal	$ 37,284,148	587,831	$63.43	18.2%	14.0%
Skin & Subcutaneous Disease	$ 14,828,551	261,000	$56.81	7.2%	6.2%
Nutritional Disease	$ 8,415,829	324,846	$25.91	4.1%	7.7%
Kidney/Urinary Tract	$ 10,648,033	274,892	$38.74	5.2%	6.5%
Male Reproductive Sys	$ 3,791,351	44,738	$84.75	1.9%	1.1%
Female Reproductive Sys	$ 7,825,164	163,635	$47.82	3.8%	3.9%
Pregnancy	$ 1,620,452	38,636	$41.94	0.8%	0.9%
Newborns in Perinatal Period	$ 67,945	1,127	$60.29	0.0%	0.0%
Disease of the Blood	$ 4,036,167	143,499	$28.13	2.0%	3.4%
Neoplasms	$ 7,462,130	132,002	$56.53	3.6%	3.1%
Infectious Disease	$ 876,845	35,715	$24.55	0.4%	0.8%
Mental Disorders	$ 854,084	21,947	$38.92	0.4%	0.5%
Alcohol/Drug Abuse	$ 297,475	10,151	$29.30	0.1%	0.2%
Injury Poisoning	$ 1,626,341	26,452	$61.48	0.8%	0.6%
Burns	$ 121,223	1,385	$87.53	0.1%	0.0%
Factors Influencing Health Status	$ 23,310,977	482,812	$48.28	11.4%	11.5%
Human Immunodeficiency Virus Infections	$ 100,889	2,273	$44.39	0.0%	0.1%
Other	$ 167,289	4,009	$41.73	0.1%	0.1%
Unknown	$ 1,696,546	10,196	$166.39	0.8%	0.2%
Total	**$ 204,726,602**	**4,212,154**	**$48.60**	**100.0%**	**100.0%**

Appendix – A4

Hospital Provider Class – Outpatient

2010 Cost, Use, and Price Experience by Top 50 Diagnoses

Outpatient Hospital by Top 50 Diagnoses	Two year average rate of change Per 1000 Members			2010 Payments	2010 Visits	Avg Pmt/Vst	% of Total Payout
	Payments	Visits	Pmt/Vst				
Antineoplastic Chemo Enc	113.9%	54.7%	38.2%	$ 4,524,274	1,287	$ 3,515	9.1%
Crnry Athrscl Natve Vssl	25.3%	0.4%	24.7%	$ 4,314,357	1,166	$ 3,700	8.7%
Other And Unspecified Hyperlipidemia	-7.0%	9.1%	-14.8%	$ 560,929	11,291	$ 50	1.1%
Abdmnal Pain Unspcf Site	-1.5%	13.7%	-13.3%	$ 1,106,525	3,575	$ 310	2.2%
Other Chest Pain	7.4%	8.9%	-1.4%	$ 2,256,780	1,385	$ 1,629	4.6%
Routine General Medical Examination A	-74.9%	204.3%	-91.8%	$ 632,555	8,285	$ 76	1.3%
Unspecified Chest Pain	-1.3%	11.0%	-11.1%	$ 2,220,699	2,590	$ 857	4.5%
Malignant Neoplasm Of Breast (Female)	13.2%	16.3%	-2.6%	$ 2,857,932	3,166	$ 903	5.8%
Dmii Wo Cmp Nt St Uncntr	0.0%	6.3%	-6.0%	$ 491,314	7,687	$ 64	1.0%
Screen Mammogram Nec	16.7%	7.4%	8.6%	$ 2,797,440	17,164	$ 163	5.6%
Unspecified Essential Hypertension	-8.5%	6.7%	-14.2%	$ 652,417	6,503	$ 100	1.3%
Unspecified Anemia	21.5%	12.6%	7.9%	$ 407,275	4,168	$ 98	0.8%
Malaise And Fatigue Nec	18.4%	21.1%	-2.3%	$ 428,251	4,201	$ 102	0.9%
Pure Hypercholesterolemia	-4.3%	9.3%	-12.4%	$ 232,818	5,038	$ 46	0.5%
Urinary Tract Infection, Site Not Specifi	-8.2%	16.6%	-21.2%	$ 402,983	5,889	$ 68	0.8%
Atrial Fibrillation	156.9%	3.2%	148.8%	$ 2,562,600	4,343	$ 590	5.2%
Unspecified Iron Deficiency Anemia	6.1%	18.1%	-10.2%	$ 139,500	712	$ 196	0.3%
Rheumatoid Arthritis	58.3%	18.2%	34.0%	$ 1,081,844	1,657	$ 653	2.2%
Unspecified Hypothyroidism	0.2%	12.6%	-11.0%	$ 286,922	5,426	$ 53	0.6%
Headache	0.6%	7.1%	-6.0%	$ 1,026,459	1,656	$ 620	2.1%
Abdmnal Pain Oth Spcf St	-1.5%	13.3%	-13.0%	$ 624,559	932	$ 670	1.3%
Multiple Sclerosis	22.0%	4.5%	16.7%	$ 494,080	495	$ 998	1.0%
Other Diseases Of Lung, Not Elsewhere	4.6%	-3.4%	8.2%	$ 502,781	723	$ 695	1.0%
Rotator Cuff (Capsule) Sprain And Strain	7.3%	13.7%	-5.6%	$ 640,663	408	$ 1,570	1.3%
Carbuncle And Furuncle Of Trunk	760.5%	251.7%	144.7%	$ 13,322	48	$ 278	0.0%
Calculus Of Kidney	27.5%	20.6%	5.8%	$ 1,287,360	1,630	$ 790	2.6%
Calculus Of Ureter	19.4%	20.6%	-0.9%	$ 1,156,311	693	$ 1,669	2.3%
Screening For Malignant Neoplasm Of T	15.4%	9.6%	5.3%	$ 586,237	10,716	$ 55	1.2%
Chemotherapy Follow-Up Examination	276.2%	131.0%	62.8%	$ 951,343	319	$ 2,982	1.9%
Malignant Neoplasm Of Prostate	13.5%	1.7%	11.6%	$ 2,110,154	1,716	$ 1,230	4.3%
Malignant Neoplasm Of Bronchus And L	13.3%	-0.3%	13.6%	$ 896,596	817	$ 1,097	1.8%
Unspecified Disorders Of Bursae And Te	-18.3%	-6.9%	-12.2%	$ 526,240	414	$ 1,271	1.1%
Oth Lymp Unsp Xtrndl Org	59776.3%	35277.6%	69.2%	$ 1,052,412	852	$ 1,235	2.1%
Hematuria, Unspecified	1.0%	16.5%	-13.3%	$ 267,570	1,414	$ 189	0.5%
Special Screening For Malignant Neopla	-3.5%	-13.4%	11.5%	$ 1,036,218	1,617	$ 641	2.1%
End Stage Renal Disease	-48.7%	-27.0%	-29.6%	$ 328,465	164	$ 2,003	0.7%
Malignant Neoplasm Of Colon, Unspecif	39.0%	18.5%	17.3%	$ 504,227	431	$ 1,170	1.0%
Abdmnal Pain Rt Lwr Quad	-1.6%	8.7%	-9.5%	$ 344,561	426	$ 809	0.7%
React-Cardiac Dev/Graft	0.0%	36.6%	-26.8%	$ 11,276	34	$ 332	0.0%
Calculus Of Gallbladder With Other Cho	9.3%	7.7%	1.5%	$ 720,035	210	$ 3,429	1.5%
Lumbago	0.4%	12.2%	-10.5%	$ 1,314,308	2,713	$ 484	2.7%
Malignant Neoplasm Of Rectum	300.4%	136.1%	69.5%	$ 522,710	309	$ 1,692	1.1%
Malignant Neoplasm Of Other Specified	33.2%	33.8%	-0.5%	$ 1,062,407	1,141	$ 931	2.1%
Essential Hypertension, Benign	-6.5%	18.8%	-21.3%	$ 127,779	2,499	$ 51	0.3%
Pain In Soft Tissues Of Limb	2.0%	7.5%	-5.1%	$ 609,201	2,136	$ 285	1.2%
Regional Enteritis Of Unspecified Site	50.3%	25.4%	19.8%	$ 686,769	577	$ 1,190	1.4%
Diarrhea	8.9%	13.9%	-4.4%	$ 258,025	1,444	$ 179	0.5%
Inguinal Hernia Without Mention Of Obs	28.3%	15.9%	10.7%	$ 565,723	281	$ 2,013	1.1%
Benign Neoplasm Of Colon	3.0%	-4.0%	7.3%	$ 807,319	1,171	$ 689	1.6%
Excessive Or Frequent Menstruation	40.3%	31.5%	6.7%	$ 557,635	744	$ 750	1.1%
Top 50 Total	19.1%	15.8%	2.9%	$ 49,550,160	134,263	$ 369	33.5%
Grand Total	**4.2%**	**2.6%**	**1.6%**	**$ 148,058,419**	**3,573,764**	**$41.43**	**100.0%**

Appendix – A4

Hospital Provider Class – Outpatient
2009 Cost, Use, and Price
Experience by Top 50 Diagnoses Codes

Outpatient Hospital by Top 50 Diagnoses	Two year average rate of change Per 1000 Members			2009	2009	Avg	% of Total
	Payments	Visits	Pmt/Vst	Payments	Visits	Pmt/Vst	Payout
Antineoplastic Chemo Enc	14.9%	11.4%	3.2%	$ 2,634,929	1,036	$ 2,543	5.1%
Crnry Athrscl Natve Vssl	15.6%	16.3%	-0.6%	$ 4,290,403	1,446	$ 2,967	8.3%
Other And Unspecified Hyperlipidemia	-27.9%	3.1%	-30.1%	$ 751,365	12,888	$ 58	1.5%
Abdmnal Pain Unspcf Site	-12.2%	2.5%	-14.3%	$ 1,398,949	3,918	$ 357	2.7%
Other Chest Pain	2.6%	9.2%	-6.1%	$ 2,618,283	1,584	$ 1,653	5.1%
Routine General Medical Examination A	3917.1%	310.5%	878.6%	$ 3,145,166	3,392	$ 927	6.1%
Unspecified Chest Pain	-11.4%	-6.2%	-5.5%	$ 2,802,605	2,907	$ 964	5.4%
Malignant Neoplasm Of Breast (Female)	11.6%	-0.6%	12.3%	$ 3,145,166	3,392	$ 927	6.1%
Dmii Wo Cmp Nt St Uncntr	-34.5%	-4.9%	-31.1%	$ 611,985	9,004	$ 68	1.2%
Screen Mammogram Nec	14.1%	7.1%	6.5%	$ 2,986,227	19,905	$ 150	5.8%
Unspecified Essential Hypertension	-22.8%	1.0%	-23.6%	$ 888,001	7,593	$ 117	1.7%
Unspecified Anemia	-39.3%	5.7%	-42.5%	$ 417,498	4,610	$ 91	0.8%
Malaise And Fatigue Nec	-24.5%	10.0%	-31.4%	$ 450,651	4,321	$ 104	0.9%
Pure Hypercholesterolemia	-35.4%	-3.8%	-32.9%	$ 303,002	5,741	$ 53	0.6%
Urinary Tract Infection, Site Not Specifi	-8.6%	5.7%	-13.5%	$ 546,553	6,291	$ 87	1.1%
Atrial Fibrillation	19.9%	-6.1%	27.7%	$ 1,242,528	5,240	$ 237	2.4%
Unspecified Iron Deficiency Anemia	10.9%	24.1%	-10.6%	$ 163,792	751	$ 218	0.3%
Rheumatoid Arthritis	8.8%	0.3%	8.5%	$ 851,179	1,747	$ 487	1.6%
Unspecified Hypothyroidism	-35.0%	2.3%	-36.4%	$ 356,690	6,001	$ 59	0.7%
Headache	72.8%	63.2%	5.8%	$ 1,270,752	1,927	$ 659	2.5%
Abdmnal Pain Oth Spcf St	0.5%	10.5%	-9.1%	$ 789,839	1,025	$ 771	1.5%
Multiple Sclerosis	-0.4%	14.0%	-12.7%	$ 504,545	590	$ 855	1.0%
Other Diseases Of Lung, Not Elsewhere (	-18.1%	-1.1%	-17.1%	$ 598,836	932	$ 643	1.2%
Rotator Cuff (Capsule) Sprain And Strain	-8.9%	-7.9%	-1.1%	$ 743,524	447	$ 1,663	1.4%
Carbuncle And Furuncle Of Trunk	41.2%	260.0%	-60.8%	$ 1,929	17	$ 113	0.0%
Calculus Of Kidney	-4.3%	2.0%	-6.2%	$ 1,257,544	1,684	$ 747	2.4%
Calculus Of Ureter	-7.2%	4.6%	-11.3%	$ 1,205,986	716	$ 1,684	2.3%
Screening For Malignant Neoplasm Of T	-13.0%	2.9%	-15.5%	$ 632,914	12,184	$ 52	1.2%
Chemotherapy Follow-Up Examination	1202.2%	295.9%	228.9%	$ 315,021	172	$ 1,832	0.6%
Malignant Neoplasm Of Prostate	-3.0%	4.1%	-6.8%	$ 2,316,135	2,102	$ 1,102	4.5%
Malignant Neoplasm Of Bronchus And L	-1.6%	-5.5%	4.2%	$ 985,916	1,021	$ 966	1.9%
Unspecified Disorders Of Bursae And Te	3.8%	22.2%	-15.0%	$ 801,942	554	$ 1,448	1.5%
Oth Lymp Unsp Xtrndl Org	-99.8%	-99.7%	-29.9%	$ 2,189	3	$ 730	0.0%
Hematuria, Unspecified	188.0%	321.3%	-31.6%	$ 330,114	1,512	$ 218	0.6%
Special Screening For Malignant Neoplas	-7.6%	2.1%	-9.5%	$ 1,337,358	2,326	$ 575	2.6%
End Stage Renal Disease	13.1%	28.3%	-11.9%	$ 796,901	280	$ 2,846	1.5%
Malignant Neoplasm Of Colon, Unspecif	-41.1%	-27.5%	-18.8%	$ 451,817	453	$ 997	0.9%
Abdmnal Pain Rt Lwr Quad	-3.8%	2.5%	-6.2%	$ 436,081	488	$ 894	0.8%
React-Cardiac Dev/Graft	-23.8%	228.3%	-76.8%	$ 14,048	31	$ 453	0.0%
Calculus Of Gallbladder With Other Cho	-18.5%	-4.7%	-14.4%	$ 820,521	243	$ 3,377	1.6%
Lumbago	-15.9%	2.6%	-18.1%	$ 1,631,276	3,013	$ 541	3.1%
Malignant Neoplasm Of Rectum	-4.9%	-19.7%	18.4%	$ 162,639	163	$ 998	0.3%
Malignant Neoplasm Of Other Specified	5.3%	19.5%	-11.9%	$ 993,475	1,062	$ 935	1.9%
Essential Hypertension, Benign	-21.2%	11.8%	-29.5%	$ 170,210	2,621	$ 65	0.3%
Pain In Soft Tissues Of Limb	-4.6%	1.9%	-6.4%	$ 743,887	2,476	$ 300	1.4%
Regional Enteritis Of Unspecified Site	-19.2%	0.5%	-19.6%	$ 569,130	573	$ 993	1.1%
Diarrhea	-17.0%	7.6%	-22.8%	$ 295,132	1,579	$ 187	0.6%
Inguinal Hernia Without Mention Of Obs	-24.8%	-8.1%	-18.1%	$ 549,181	302	$ 1,818	1.1%
Benign Neoplasm Of Colon	-27.0%	-9.9%	-19.0%	$ 976,375	1,519	$ 643	1.9%
Excessive Or Frequent Menstruation	-30.8%	-7.3%	-25.4%	$ 495,189	705	$ 702	1.0%
Top 50 Total	0.9%	5.1%	-4.0%	$ 51,805,377	144,487	$ 359	29.3%
Grand Total	**-8.5%**	**9.1%**	**-16.1%**	**$ 176,927,632**	**4,340,073**	**$40.77**	**100.0%**

Appendix – C4

Hospital Provider Class – Outpatient

2008 Cost, Use, and Price Experience by Top 50 Diagnoses

Outpatient Hospital by Top 50 Diagnoses	2008 Payments	2008 Visits	Avg Pmt/Vst	% of Total Payout
Antineoplastic Chemo Enc	$ 2,427,471	985	$ 2,464	4.5%
Crnry Athrscl Natve Vssl	$ 3,929,644	1,317	$ 2,984	7.2%
Other And Unspecified Hyperlipidemia	$ 1,104,013	13,234	$ 83	2.0%
Abdmnal Pain Unspcf Site	$ 1,687,714	4,049	$ 417	3.1%
Other Chest Pain	$ 2,703,290	1,536	$ 1,760	5.0%
Routine General Medical Examination A	$ 82,903	875	$ 95	0.2%
Unspecified Chest Pain	$ 3,348,031	3,283	$ 1,020	6.2%
Malignant Neoplasm Of Breast (Female)	$ 2,984,553	3,615	$ 826	5.5%
Dmii Wo Cmp Nt St Uncntr	$ 989,371	10,027	$ 99	1.8%
Screen Mammogram Nec	$ 2,771,213	19,673	$ 141	5.1%
Unspecified Essential Hypertension	$ 1,218,497	7,958	$ 153	2.2%
Unspecified Anemia	$ 727,979	4,620	$ 158	1.3%
Malaise And Fatigue Nec	$ 632,348	4,158	$ 152	1.2%
Pure Hypercholesterolemia	$ 496,899	6,318	$ 79	0.9%
Urinary Tract Infection, Site Not Specifi	$ 633,084	6,305	$ 100	1.2%
Atrial Fibrillation	$ 1,096,971	5,908	$ 186	2.0%
Unspecified Iron Deficiency Anemia	$ 156,396	641	$ 244	0.3%
Rheumatoid Arthritis	$ 828,366	1,845	$ 449	1.5%
Unspecified Hypothyroidism	$ 580,631	6,213	$ 93	1.1%
Headache	$ 778,767	1,250	$ 623	1.4%
Abdmnal Pain Oth Spcf St	$ 832,506	982	$ 848	1.5%
Multiple Sclerosis	$ 536,554	548	$ 979	1.0%
Other Diseases Of Lung, Not Elsewhere	$ 773,769	998	$ 775	1.4%
Rotator Cuff (Capsule) Sprain And Strai	$ 864,538	514	$ 1,682	1.6%
Carbuncle And Furuncle Of Trunk	$ 1,446	5	$ 289	0.0%
Calculus Of Kidney	$ 1,391,858	1,748	$ 796	2.6%
Calculus Of Ureter	$ 1,376,098	725	$ 1,898	2.5%
Screening For Malignant Neoplasm Of T	$ 770,176	12,532	$ 61	1.4%
Chemotherapy Follow-Up Examination	$ 25,616	46	$ 557	0.0%
Malignant Neoplasm Of Prostate	$ 2,528,109	2,138	$ 1,182	4.6%
Malignant Neoplasm Of Bronchus And L	$ 1,060,449	1,144	$ 927	2.0%
Unspecified Disorders Of Bursae And Te	$ 817,793	480	$ 1,704	1.5%
Oth Lymp Unsp Xtrndl Org	$ 1,075,283	1,033	$ 1,041	2.0%
Hematuria, Unspecified	$ 121,357	380	$ 319	0.2%
Special Screening For Malignant Neopla	$ 1,532,549	2,413	$ 635	2.8%
End Stage Renal Disease	$ 745,885	231	$ 3,229	1.4%
Malignant Neoplasm Of Colon, Unspecif	$ 812,811	662	$ 1,228	1.5%
Abdmnal Pain Rt Lwr Quad	$ 480,165	504	$ 953	0.9%
React-Cardiac Dev/Graft	$ 19,522	10	$ 1,952	0.0%
Calculus Of Gallbladder With Other Cho	$ 1,065,430	270	$ 3,946	2.0%
Lumbago	$ 2,055,099	3,109	$ 661	3.8%
Malignant Neoplasm Of Rectum	$ 181,172	215	$ 843	0.3%
Malignant Neoplasm Of Other Specified	$ 999,385	941	$ 1,062	1.8%
Essential Hypertension, Benign	$ 228,689	2,482	$ 92	0.4%
Pain In Soft Tissues Of Limb	$ 825,729	2,572	$ 321	1.5%
Regional Enteritis Of Unspecified Site	$ 745,959	604	$ 1,235	1.4%
Diarrhea	$ 376,348	1,554	$ 242	0.7%
Inguinal Hernia Without Mention Of Obs	$ 773,059	348	$ 2,221	1.4%
Benign Neoplasm Of Colon	$ 1,416,626	1,785	$ 794	2.6%
Excessive Or Frequent Menstruation	$ 757,567	805	$ 941	1.4%
Top 50 Total	$ 54,369,687	145,588	$ 373	26.6%
Grand Total	**$ 204,726,602**	**4,212,154**	**$48.60**	**100.0%**

Appendix – C5

Hospital Provider Class – Inpatient

2010 Cost, Use, and Price Experience by Top 50 Diagnoses

Inpatient Hospital by Top 50 Diagnoses	Two year average rate of change Per 1000 Members			2010	2010	2010	2010 Avg	2010 Avg	Pct to Total
	Payments	Days	Pmt/Adm	Payments	Days	Adm	Pmt/Day	Pmt/Adm	Payout
Crnry Athrscl Natve Vssl	-6.6%	-7.3%	11.2%	$ 11,692,510	1,829	630	$ 6,393	$ 18,560	6.6%
Loc Osteoarth Nos-L/Leg	19.7%	6.4%	11.0%	$ 7,318,169	1,184	380	$ 6,181	$ 19,258	4.2%
Rehabilitation Proc Nec	17.9%	10.4%	1.3%	$ 4,282,294	3,235	258	$ 1,324	$ 16,598	2.4%
Subendo Infarct, Initial	-2.2%	-8.7%	3.9%	$ 3,898,863	808	189	$ 4,825	$ 20,629	2.2%
Morbid Obesity	-4.6%	-8.9%	18.8%	$ 3,707,633	556	241	$ 6,668	$ 15,384	2.1%
Loc Osteoarth Nos-Pelvis	34.2%	14.7%	10.8%	$ 3,321,843	559	180	$ 5,942	$ 18,455	1.9%
Septicemia Nos	22.2%	-4.8%	14.5%	$ 2,974,931	1,224	167	$ 2,430	$ 17,814	1.7%
Chf Nos	-1.1%	-14.4%	24.9%	$ 2,874,210	824	155	$ 3,488	$ 18,543	1.6%
Osteoarthros Nos-L/Leg	11.8%	-6.8%	18.1%	$ 2,592,570	398	130	$ 6,514	$ 19,943	1.5%
Acute Respiratry Failure	-10.3%	-16.9%	-7.7%	$ 2,503,496	834	103	$ 3,002	$ 24,306	1.4%
Pneumonia, Organism Nos	-3.8%	-9.8%	3.7%	$ 2,480,879	1,243	312	$ 1,996	$ 7,952	1.4%
Single Lb In-Hosp W/O Cs	189.5%	347.8%	-81.1%	$ 2,407,510	2,193	1,268	$ 1,098	$ 1,899	1.4%
Lumbar Disc Displacement	12.8%	0.0%	16.2%	$ 2,129,320	480	226	$ 4,436	$ 9,422	1.2%
Dvrtcli Colon W/O Hmrhg	6.9%	15.4%	3.0%	$ 1,896,427	978	200	$ 1,939	$ 9,482	1.1%
Single Lb In-Hosp W Cs	40.6%	113.1%	-81.4%	$ 1,819,919	1,661	631	$ 1,096	$ 2,884	1.0%
Other Postop Infection	39.3%	8.8%	38.4%	$ 1,797,103	782	118	$ 2,298	$ 15,230	1.0%
Act Myl Leuk W/O Rmsion	133.3%	8.7%	157.5%	$ 1,794,490	356	16	$ 5,041	$ 112,156	1.0%
Subarachnoid Hemorrhage	61.8%	49.7%	23.7%	$ 1,669,163	346	21	$ 4,824	$ 79,484	0.9%
Acute Pancreatitis	27.6%	6.9%	-4.0%	$ 1,658,157	981	191	$ 1,690	$ 8,681	0.9%
Malign Neopl Prostate	28.2%	20.9%	13.8%	$ 1,608,939	297	142	$ 5,417	$ 11,331	0.9%
Antineoplastic Chemo Enc	25.4%	10.9%	41.6%	$ 1,608,198	722	118	$ 2,227	$ 13,629	0.9%
Acute Renal Failure Nos	23.3%	26.1%	-4.7%	$ 1,528,814	748	136	$ 2,044	$ 11,241	0.9%
Osteoarthros Nos-Pelvis	45.1%	19.2%	7.4%	$ 1,525,673	242	77	$ 6,304	$ 19,814	0.9%
Atrial Fibrillation	-25.9%	-12.5%	-3.9%	$ 1,441,678	594	197	$ 2,427	$ 7,318	0.8%
Obs Chr Bronc W(Ac) Exac	97.5%	24.1%	88.9%	$ 1,431,582	564	110	$ 2,538	$ 13,014	0.8%
Prev C-Delivery-Delivrd	-11.0%	-1.2%	-10.3%	$ 1,412,533	690	265	$ 2,047	$ 5,330	0.8%
Pulm Embol/Infarct Nec	19.0%	5.2%	-1.1%	$ 1,283,420	625	113	$ 2,053	$ 11,358	0.7%
Spinal Stenosis-Lumbar	18.5%	0.7%	13.3%	$ 1,164,365	245	84	$ 4,753	$ 13,861	0.7%
Recur Depr Psych-Severe	21.8%	13.9%	8.7%	$ 1,118,406	1,222	233	$ 915	$ 4,800	0.6%
Ami Inferior Wall, Init	-7.4%	-29.5%	-6.1%	$ 1,090,673	158	57	$ 6,903	$ 19,135	0.6%
Crbl Art Ocl Nos W Infrc	2.3%	-9.5%	8.4%	$ 1,060,149	409	100	$ 2,592	$ 10,601	0.6%
Chest Pain Nec	13.1%	-5.0%	14.8%	$ 1,050,850	324	178	$ 3,243	$ 5,904	0.6%
Dsct Of Thoracic Aorta	1306.6%	820.2%	142.0%	$ 947,837	229	14	$ 4,139	$ 67,703	0.5%
Loc Prim Osteoart-L/Leg	36.9%	8.8%	18.5%	$ 931,696	159	51	$ 5,860	$ 18,269	0.5%
Acute Appendicitis Nos	-5.6%	-16.3%	6.6%	$ 926,435	252	150	$ 3,676	$ 6,176	0.5%
Intestinal Adhes W Obstr	20.6%	26.8%	12.9%	$ 916,945	458	54	$ 2,002	$ 16,980	0.5%
Ocl Crtd Art Wo Infrct	30.8%	-5.1%	12.9%	$ 898,786	128	79	$ 7,022	$ 11,377	0.5%
Malig Neo Corpus Uteri	121.7%	91.6%	59.6%	$ 865,255	260	58	$ 3,328	$ 14,918	0.5%
Sec Mal Neo Brain/Spine	69.1%	81.1%	6.9%	$ 838,847	285	47	$ 2,943	$ 17,848	0.5%
Cervical Disc Displacmnt	-13.4%	-13.2%	-3.8%	$ 827,441	131	86	$ 6,316	$ 9,621	0.5%
React-Oth Vasc Dev/Graft	-0.8%	-6.1%	9.5%	$ 827,063	515	56	$ 1,606	$ 14,769	0.5%
Aortic Valve Disorder	-8.5%	-31.6%	15.5%	$ 806,655	135	21	$ 5,975	$ 38,412	0.5%
Mitral Valve Disorder	28.0%	26.3%	33.0%	$ 764,544	143	17	$ 5,346	$ 44,973	0.4%
Food/Vomit Pneumonitis	60.2%	44.4%	22.6%	$ 761,932	342	43	$ 2,228	$ 17,719	0.4%
Cellulitis Of Leg	14.2%	-14.7%	9.5%	$ 758,577	522	129	$ 1,453	$ 5,880	0.4%
Cholelith W Ac Cholecyst	69.9%	8.1%	32.4%	$ 754,996	203	69	$ 3,719	$ 10,942	0.4%
Acq Spondylolisthesis	39.3%	10.4%	24.6%	$ 740,798	125	35	$ 5,926	$ 21,166	0.4%
Intramural Leiomyoma	-4.4%	-13.7%	12.6%	$ 732,463	223	92	$ 3,285	$ 7,962	0.4%
Ami Anterior Wall, Init	-19.8%	-34.3%	-3.4%	$ 729,781	126	28	$ 5,792	$ 26,064	0.4%
Abdom Aortic Aneurysm	55.4%	20.1%	-0.2%	$ 710,206	81	25	$ 8,768	$ 28,408	0.4%
Other	-22.7%	-43.9%	37.0%	$ 81,304,234	17,366	4,636	$ 4,682	$ 17,538	46.1%
Top 50 Diagnosis	14.9%	12.0%	-8.8%	$ 94,885,022	31,628	8,280	$ 3,000	$ 11,460	53.9%
GRAND TOTAL	**-6.2%**	**-12.7%**	**7.4%**	**$ 176,189,256**	**48,994**	**12,916**	**$ 3,596**	**$ 13,641**	**100%**

Appendix – A5

Hospital Provider Class – Inpatient

2009 Cost, Use, and Price Experience by Top 50 Diagnoses

Inpatient Hospital by Top 50 Diagnoses	Two year average rate of change Per 1000 Members			2009 Payments	2009 Days	2009 Adm	2009 Avg Pmt/Day	2009 Avg Pmt/Adm	Pct to Total Payout
	Payments	Days	Pmt/Adm						
Crnry Athrscl Natve Vssl	-32.6%	-39.4%	6.9%	$ 15,592,475	2,458	934	$ 6,344	$ 16,694	6.7%
Loc Osteoarth Nos-L/Leg	-24.2%	-30.1%	8.5%	$ 7,614,903	1,386	439	$ 5,494	$ 17,346	3.3%
Rehabilitation Proc Nec	-21.5%	-25.1%	16.3%	$ 4,523,961	3,649	276	$ 1,240	$ 16,391	1.9%
Subendo Infarct, Initial	-24.3%	-27.9%	17.3%	$ 4,965,280	1,102	250	$ 4,506	$ 19,861	2.1%
Morbid Obesity	-28.0%	-42.8%	1.5%	$ 4,843,002	760	374	$ 6,372	$ 12,949	2.1%
Loc Osteoarth Nos-Pelvis	-28.8%	-33.6%	5.8%	$ 3,082,456	607	185	$ 5,078	$ 16,662	1.3%
Septicemia Nos	20.9%	15.2%	21.2%	$ 3,032,575	1,601	195	$ 1,894	$ 15,552	1.3%
Chf Nos	-30.9%	-32.6%	-8.7%	$ 3,621,607	1,199	244	$ 3,021	$ 14,843	1.5%
Osteoarthros Nos-L/Leg	-22.4%	-33.6%	5.4%	$ 2,887,785	532	171	$ 5,428	$ 16,888	1.2%
Acute Respiratry Failure	-19.8%	-18.5%	-0.7%	$ 3,475,021	1,250	132	$ 2,780	$ 26,326	1.5%
Pneumonia, Organism Nos	-27.8%	-35.5%	19.3%	$ 3,214,085	1,716	419	$ 1,873	$ 7,671	1.4%
Single Lb In-Hosp W/O Cs	-26.0%	-31.8%	12.0%	$ 1,036,104	610	103	$ 1,699	$ 10,059	0.4%
Lumbar Disc Displacement	-25.3%	-26.6%	5.1%	$ 2,352,141	598	290	$ 3,933	$ 8,111	1.0%
Dvrtcli Colon W/O Hmrhg	-16.0%	-31.7%	16.6%	$ 2,209,568	1,056	240	$ 2,092	$ 9,207	0.9%
Single Lb In-Hosp W Cs	-54.2%	-51.5%	-29.6%	$ 1,612,954	971	104	$ 1,661	$ 15,509	0.7%
Other Postop Infection	-21.3%	-19.6%	8.9%	$ 1,607,011	895	146	$ 1,796	$ 11,007	0.7%
Act Myl Leuk W/O Rmsion	-20.1%	-27.5%	-17.7%	$ 958,205	408	22	$ 2,349	$ 43,555	0.4%
Subarachnoid Hemorrhage	-0.6%	-10.3%	40.8%	$ 1,285,358	288	20	$ 4,463	$ 64,268	0.5%
Acute Pancreatitis	-33.1%	-23.4%	2.7%	$ 1,619,107	1,143	179	$ 1,417	$ 9,045	0.7%
Malign Neopl Prostate	-29.3%	-40.9%	3.8%	$ 1,563,863	306	157	$ 5,111	$ 9,961	0.7%
Antineoplastic Chemo Enc	267.4%	201.3%	-12.2%	$ 1,597,320	811	166	$ 1,970	$ 9,622	0.7%
Acute Renal Failure Nos	-20.0%	-33.9%	13.0%	$ 1,545,092	739	131	$ 2,091	$ 11,795	0.7%
Osteoarthros Nos-Pelvis	2.1%	-14.4%	15.5%	$ 1,310,190	253	71	$ 5,179	$ 18,453	0.6%
Atrial Fibrillation	-18.4%	-30.3%	11.0%	$ 2,422,745	846	318	$ 2,864	$ 7,619	1.0%
Obs Chr Bronc W(Ac) Exac	-44.2%	-47.3%	-11.4%	$ 902,744	566	131	$ 1,595	$ 6,891	0.4%
Prev C-Delivery-Delivrd	-33.6%	-35.0%	2.4%	$ 1,977,778	870	333	$ 2,273	$ 5,939	0.8%
Pulm Embol/Infarct Nec	-16.5%	-15.6%	7.1%	$ 1,342,978	740	117	$ 1,815	$ 11,478	0.6%
Spinal Stenosis-Lumbar	-29.9%	-34.9%	7.2%	$ 1,223,752	303	100	$ 4,039	$ 12,238	0.5%
Recur Depr Psych-Severe	-4.4%	-14.7%	19.5%	$ 1,143,982	1,336	259	$ 856	$ 4,417	0.5%
Ami Inferior Wall, Init	-33.0%	-33.2%	2.8%	$ 1,466,931	279	72	$ 5,258	$ 20,374	0.6%
Crbl Art Ocl Nos W Infrc	-34.5%	-39.2%	-1.6%	$ 1,291,516	563	132	$ 2,294	$ 9,784	0.6%
Chest Pain Nec	-35.7%	-38.1%	-0.4%	$ 1,157,085	425	225	$ 2,723	$ 5,143	0.5%
Dsct Of Thoracic Aorta	-86.0%	-86.3%	-29.3%	$ 83,940	31	3	$ 2,708	$ 27,980	0.0%
Loc Prim Osteoart-L/Leg	-31.1%	-26.2%	-3.0%	$ 847,928	182	55	$ 4,659	$ 15,417	0.4%
Acute Appendicitis Nos	-21.8%	-28.1%	8.8%	$ 1,222,571	375	211	$ 3,260	$ 5,794	0.5%
Intestinal Adhes W Obstr	-18.0%	-38.8%	19.3%	$ 947,280	450	63	$ 2,105	$ 15,036	0.4%
Ocl Crtd Art Wo Infrct	-33.7%	-33.9%	6.8%	$ 856,286	168	85	$ 5,097	$ 10,074	0.4%
Malig Neo Corpus Uteri	-45.0%	-49.0%	0.9%	$ 486,202	169	52	$ 2,877	$ 9,350	0.2%
Sec Mal Neo Brain/Spine	-45.8%	-51.4%	17.5%	$ 618,030	196	37	$ 3,153	$ 16,704	0.3%
Cervical Disc Displacmnt	-10.3%	-21.0%	18.2%	$ 1,190,693	188	119	$ 6,333	$ 10,006	0.5%
React-Oth Vasc Dev/Graft	6.8%	14.1%	6.1%	$ 1,038,817	683	77	$ 1,521	$ 13,491	0.4%
Aortic Valve Disorder	-21.4%	6.3%	-5.5%	$ 1,097,781	246	33	$ 4,463	$ 33,266	0.5%
Mitral Valve Disorder	-42.1%	-27.9%	-15.4%	$ 743,767	141	22	$ 5,275	$ 33,808	0.3%
Food/Vomit Pneumonitis	-31.8%	-48.5%	0.5%	$ 592,626	295	41	$ 2,009	$ 14,454	0.3%
Cellulitis Of Leg	-24.9%	-21.9%	6.0%	$ 827,353	762	154	$ 1,086	$ 5,372	0.4%
Cholelith W Ac Cholecyst	-26.1%	-17.1%	-4.1%	$ 553,625	234	67	$ 2,366	$ 8,263	0.2%
Acq Spondylolisthesis	-30.2%	-28.6%	-2.0%	$ 662,376	141	39	$ 4,698	$ 16,984	0.3%
Intramural Leiomyoma	-28.4%	-38.5%	7.1%	$ 954,717	322	135	$ 2,965	$ 7,072	0.4%
Ami Anterior Wall, Init	-36.0%	-46.4%	15.2%	$ 1,133,711	239	42	$ 4,744	$ 26,993	0.5%
Abdom Aortic Aneurysm	-55.6%	-70.6%	-16.2%	$ 569,475	84	20	$ 6,779	$ 28,474	0.2%
Other	108.5%	60.0%	26.4%	$ 131,018,360	38,535	10,233	$ 3,400	$ 12,804	56.0%
Top 50 Diagnosis	-26.1%	-29.1%	5.6%	$ 102,906,755	35,172	8,190	$ 2,926	$ 12,565	44.0%
GRAND TOTAL	**9.7%**	**-3.0%**	**13.2%**	**$ 233,925,115**	**73,707**	**18,423**	**$ 3,174**	**$ 12,697**	**100%**

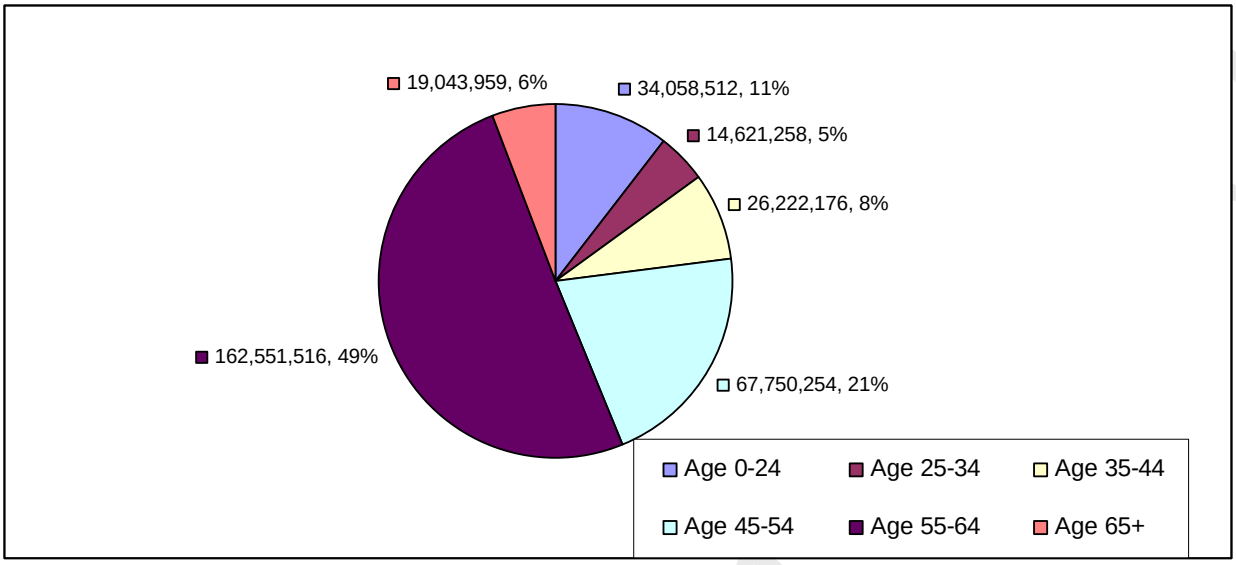
Appendix – A5

Hospital Provider Class – Inpatient

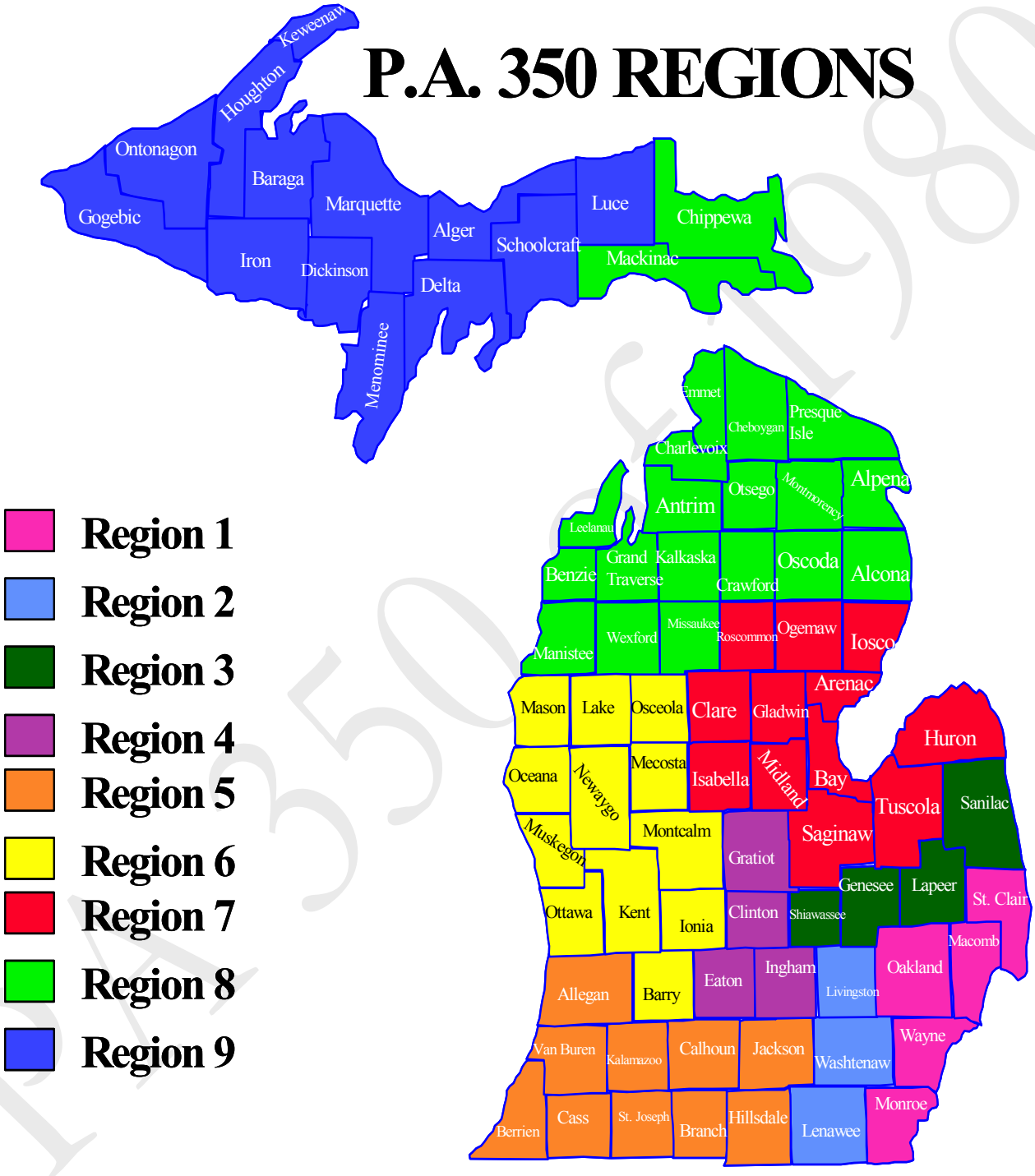
2008 Cost, Use, and Price Experience by Top 50 Diagnoses

Inpatient Hospital by Top 50 Diagnoses	2008 Payments	2008 Days	2008 Adm	2008 Avg Pmt/Day	2008 Avg Pmt/Adm	Pct to Total Payout
Crnry Athrscl Natve Vssl	$ 24,497,985	4,295	1,568	$ 5,704	$ 15,624	10.9%
Loc Osteoarth Nos-L/Leg	$ 10,642,945	2,101	666	$ 5,066	$ 15,980	4.7%
Rehabilitation Proc Nec	$ 6,102,582	5,158	433	$ 1,183	$ 14,094	2.7%
Subendo Infarct, Initial	$ 6,943,500	1,618	410	$ 4,291	$ 16,935	3.1%
Morbid Obesity	$ 7,121,366	1,406	558	$ 5,065	$ 12,762	3.2%
Loc Osteoarth Nos-Pelvis	$ 4,581,988	968	291	$ 4,733	$ 15,746	2.0%
Septicemia Nos	$ 2,655,616	1,471	207	$ 1,805	$ 12,829	1.2%
Chf Nos	$ 5,546,241	1,884	341	$ 2,944	$ 16,265	2.5%
Osteoarthros Nos-L/Leg	$ 3,939,739	849	246	$ 4,640	$ 16,015	1.7%
Acute Respiratry Failure	$ 4,588,003	1,624	173	$ 2,825	$ 26,520	2.0%
Pneumonia, Organism Nos	$ 4,711,179	2,819	733	$ 1,671	$ 6,427	2.1%
Single Lb In-Hosp W/O Cs	$ 1,482,320	947	165	$ 1,565	$ 8,984	0.7%
Lumbar Disc Displacement	$ 3,333,803	863	432	$ 3,863	$ 7,717	1.5%
Dvrtcli Colon W/O Hmrhg	$ 2,786,821	1,637	353	$ 1,702	$ 7,895	1.2%
Single Lb In-Hosp W Cs	$ 3,725,424	2,118	169	$ 1,759	$ 22,044	1.7%
Other Postop Infection	$ 2,162,001	1,178	214	$ 1,835	$ 10,103	1.0%
Act Myl Leuk W/O Rmsion	$ 1,270,167	596	24	$ 2,131	$ 52,924	0.6%
Subarachnoid Hemorrhage	$ 1,369,186	340	30	$ 4,027	$ 45,640	0.6%
Acute Pancreatitis	$ 2,563,681	1,579	291	$ 1,624	$ 8,810	1.1%
Malign Neopl Prostate	$ 2,342,339	548	244	$ 4,274	$ 9,600	1.0%
Antineoplastic Chemo Enc	$ 460,325	285	42	$ 1,615	$ 10,960	0.2%
Acute Renal Failure Nos	$ 2,046,275	1,183	196	$ 1,730	$ 10,440	0.9%
Osteoarthros Nos-Pelvis	$ 1,358,620	313	85	$ 4,341	$ 15,984	0.6%
Atrial Fibrillation	$ 3,143,347	1,286	458	$ 2,444	$ 6,863	1.4%
Obs Chr Bronc W(Ac) Exac	$ 1,711,618	1,137	220	$ 1,505	$ 7,780	0.8%
Prev C-Delivery-Delivrd	$ 3,154,875	1,418	544	$ 2,225	$ 5,799	1.4%
Pulm Embol/Infarct Nec	$ 1,703,634	928	159	$ 1,836	$ 10,715	0.8%
Spinal Stenosis-Lumbar	$ 1,849,424	493	162	$ 3,751	$ 11,416	0.8%
Recur Depr Psych-Severe	$ 1,267,437	1,658	343	$ 764	$ 3,695	0.6%
Ami Inferior Wall, Init	$ 2,319,729	442	117	$ 5,248	$ 19,827	1.0%
Crbl Art Ocl Nos W Infrc	$ 2,087,613	980	210	$ 2,130	$ 9,941	0.9%
Chest Pain Nec	$ 1,905,719	727	369	$ 2,621	$ 5,165	0.8%
Dsct Of Thoracic Aorta	$ 632,923	239	16	$ 2,648	$ 39,558	0.3%
Loc Prim Osteoart-L/Leg	$ 1,302,622	261	82	$ 4,991	$ 15,886	0.6%
Acute Appendicitis Nos	$ 1,655,689	552	311	$ 2,999	$ 5,324	0.7%
Intestinal Adhes W Obstr	$ 1,222,729	778	97	$ 1,572	$ 12,605	0.5%
Ocl Crtd Art Wo Infrct	$ 1,367,622	269	145	$ 5,084	$ 9,432	0.6%
Malig Neo Corpus Uteri	$ 936,316	351	101	$ 2,668	$ 9,270	0.4%
Sec Mal Neo Brain/Spine	$ 1,207,929	427	85	$ 2,829	$ 14,211	0.5%
Cervical Disc Displacmnt	$ 1,405,369	252	166	$ 5,577	$ 8,466	0.6%
React-Oth Vasc Dev/Graft	$ 1,029,703	634	81	$ 1,624	$ 12,712	0.5%
Aortic Valve Disorder	$ 1,478,125	245	42	$ 6,033	$ 35,193	0.7%
Mitral Valve Disorder	$ 1,359,288	207	34	$ 6,567	$ 39,979	0.6%
Food/Vomit Pneumonitis	$ 920,236	607	64	$ 1,516	$ 14,379	0.4%
Cellulitis Of Leg	$ 1,166,145	1,033	230	$ 1,129	$ 5,070	0.5%
Cholelith W Ac Cholecyst	$ 792,850	299	92	$ 2,652	$ 8,618	0.4%
Acq Spondylolisthesis	$ 1,004,936	209	58	$ 4,808	$ 17,326	0.4%
Intramural Leiomyoma	$ 1,412,494	554	214	$ 2,550	$ 6,600	0.6%
Ami Anterior Wall, Init	$ 1,874,773	472	80	$ 3,972	$ 23,435	0.8%
Abdom Aortic Aneurysm	$ 1,358,401	303	40	$ 4,483	$ 33,960	0.6%
Other	$ 78,279,034	30,007	7,730	$ 2,609	$ 10,127	34.7%
Top 50 Diagnosis	$ 147,503,651	52,541	12,391	$ 2,807	$ 11,904	65.3%
GRAND TOTAL	**$ 225,782,685**	**82,548**	**20,121**	**$ 2,735**	**$ 11,221**	**100%**

Appendix – A6
Hospital Provider Class
2010 Payments by Age: Overall Hospital Costs



APPENDIX D



APPENDIX E

BCBSM Hospital Audit Activities

2009 – 2010

Audit Activity	2009	2010
DRG Validation		
Number of Hospitals	102	100
Cases Reviewed	19,293	17,499
Identified Savings	$31,031,304	$36,585,684
Recoveries to date	$24,707,242	$24,010,997
Catastrophic Claims		
Cases Audited	159	141
Identified Savings	$4,276,481	$3,652,711
Recoveries to date	$3,246,244	$2,401,064
Readmission Audits		
Number of Audits	120	113
Identified Savings	$8,046,738	$10,371,081
Recoveries to date	$7,133,059	$6,948,064
Peer Group 5		
Number of Hospitals	6	5
Cases Reviewed	11	6
Identified Savings	$4,348	$0
Transfer Audits		
Number of Hospitals	66	63
Cases Reviewed	95	102
Savings	$1,002,132	$863,774
Hospital Outpatient Audits		
Number of Audits	190	180
Identified Savings	$5,732,459	$1,914,028
Recoveries to date	$3,508,502	$4,742,347